



HONORING THE CALL TO DUTY:

VETERANS' DISABILITY BENEFITS IN THE 21ST CENTURY



VETERANS' DISABILITY BENEFITS COMMISSION

**Honoring the Call to Duty:
Veterans' Disability Benefits in the 21st Century**

**Veterans' Disability Benefits Commission
October 2007**

Veterans' Disability Benefits Commission
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The Veterans' Disability Benefits Commission is pleased to submit to you our report, *Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century*. The Commission's recommendations aim to ensure that disability benefits fairly compensate service-disabled veterans and their families, and help them live with dignity as they rehabilitate and reintegrate into civilian life.

The Commission was created to study the benefits and services intended to compensate and assist veterans and their survivors for disabilities and deaths attributable to

military service. To accomplish this undertaking, the Commission embarked upon a thorough, comprehensive, and objective analysis of the full range of benefit programs.

The Commission engaged the analytical support of two well-established research organizations, the Institute of Medicine (IOM) of the National Academies and CNA Corporation (CNAC) to provide a data-driven, evidence-based foundation for the findings and recommendations in this report. With contributions from IOM and CNAC, the Commission addressed the appropriateness and purpose of the benefits, the benefit levels and payment rates, and the processes and procedures used to determine eligibility.

Special attention was given to the care of the severely injured, treatment and compensation for posttraumatic stress disorder, transition from military service to civilian life, the rating schedule used to assess disability, the methodologies applied to establishing presumptive service-connection for disabilities, individual unemployability, and the timeliness of claims processing.

The Commission also conducted fact-finding visits to eight cities around the country, held public hearings, carried out surveys, and reviewed studies and research regarding programmatic and organizational improvements to the veterans' disability benefits system. As part of the public hearings, the Commission heard extensive testimony from veterans, advocates, and family members regarding the current veterans' disability system, as well as from directors, program managers and staff from the Department of Veterans Affairs, the Department of Defense, and other federal and state agencies and private sector experts.

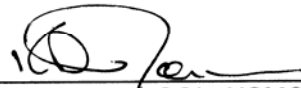
After more than two years of study, the Commission found that improvements are needed, in both the benefits received and the management and operation of the benefit programs. The recommendations of this report offer a way forward and practical solutions so that disabled veterans and their families receive appropriate, equitable, and consistent benefits honoring their service and sacrifices.

Sincerely,


JAMES TERRY SCOTT, LTG, USA (RET)
Chairman



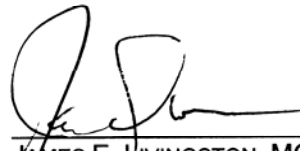
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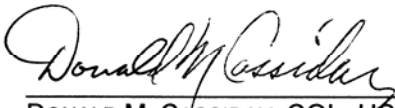
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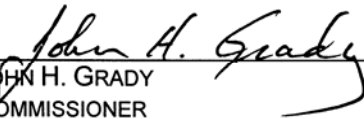
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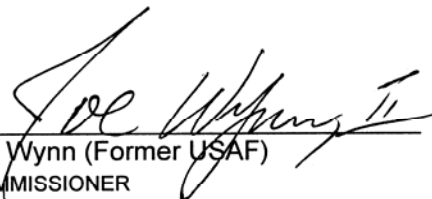
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Acknowledgements

The Veterans' Disability Benefits Commission wishes to acknowledge first and foremost all of the veterans who participated in our open public meetings, site visits, and panels, and who sent us correspondence. We are grateful for their dedication to assisting fellow veterans by sharing their perspectives. We also appreciate the representatives from veterans service organizations who diligently provided us with important information. In particular, the Commission would like to thank Steve Smithson of The American Legion, Joe Violante of Disabled American Veterans, Gerald Manar of Veterans of Foreign Wars, Rick Weidman of Vietnam Veterans of America, Mike Hayden of the Military Officers Association of America, Edith Smith of Gold Star Wives, and Barbara Cohoon and Kathleen Moakler of the National Military Family Association. Brad Snyder from Armed Forces Services Corporation was extremely helpful at clarifying complex cost analyses and issues regarding benefits for veterans and their families. The Commission was honored to be included by COL William O'Brien in the Severely Injured Marines and Sailors (SIMS) pilot study working group; we learned from the group's research. The Commission is also grateful to all of the expert witness who appeared before us from the Department of Veterans Affairs, Department of Defense (DoD), Department of Labor, and the Social Security Administration.

In addition, the Commission could not have completed its site visits to eight locations if not for the assistance of all of the personnel at the Veterans Benefits Administration, Veterans Health Administration, and DoD who participated in the planning and execution. The cooperation and coordination that made these visits possible was paramount and appreciated, especially the efforts of Beth McCoy and COL Melissa Applegate. The VA facility directors, military installation commanders, and their staffs were vital in ensuring productive visits. The Commission is also grateful to the local veterans service organizations and state veterans' departments who took time to meet with us and promote attendance at the town hall meetings. We learned a great deal from those organizations.

Key aspects of the Commission's work could not have been completed without the assistance and analyses of our two contractors: the CNA Corporation (CNAC) and the Institute of Medicine (IOM). Dr. Joyce McMahon, Rick Berens, Dr. Eric Christensen, Dr. Bradley Gray, Dr. Dan Harris, Dr. Ted Jaditz, Dr. Laurie May, and Elizabeth Schaefer from CNAC gave us the data and analyses we needed on issues surrounding quality of life, earnings, and disability ratings. The surveys conducted by CNAC and Macro International Inc. were vital to our understanding of what veterans need. JoAnn Kuchak of Macro International was instrumental in conducting surveys of disabled veterans and survivors. Also, Dr. Rick Erdtmann and several IOM study directors and committees provided invaluable recommendations on VA medical evaluations, presumptions, and PTSD diagnosis and compensation.

Finally, the Commission could not have completed this report without the expertise of its Executive Director, Ray Wilburn and his staff, whose collective knowledge of evaluation and veterans' benefits, disability, and healthcare was unsurpassable. The staff garnered immeasurable support from VA, especially Marcelle Habibion and George Fitzelle.

Preface

“Welcome home!” Fellow veterans understand the great sense of camaraderie that such a simple salutation brings. It is a reminder of the distant battles left imprinted on the memories of those who knew the beaches of Normandy, the cold at the Chosin Reservoir, the leeches of the Delta, and the heat of the desert. It acknowledges the sacrifices. Uttering these words is like reaching out a helping hand to another who bears battle scars. Such welcomes do not distinguish between a soldier, sailor, guardsman, airman or Marine, nor do they wait for rank. A welcome home is not limited by race or gender, nor does it require details about the mission. It comes with an unabashed handshake or embrace reinforced with a knowing smile. It is an affirmation of survival, reunion, and readjustment to civilian life. Family and stranger alike long to utter these words and show their support, whether through joyous tears, the waving of the flag, or the wearing of a red poppy.

Military homecomings are filled with such joy that it is easy to overlook the challenges and hardships on the road back to civilian life. Each generation of veterans has faced those obstacles with help from their families, friends, communities, employers, or other veterans. The greatest institutional source of assistance has come in the form of benefits from the Federal government, primarily delivered by the Departments of Defense, Veterans Affairs, Labor, and Health and Human Services. These departments have delivered medical care, compensation, education and employment assistance, home loans, survivor programs, insurance, and burial allowances to millions of veterans and their families.

Through programs sponsored by these federal departments, veterans have achieved many successes. They have brought their military experiences to classrooms, corporations, and pastures across America, sometimes overcoming daunting disabilities and impairments to do so. Other times, disabilities caused by injuries or illnesses incurred during military service have caused complications in veterans that resulted in the loss of a supportive social structure and the

disruption of individual homeostasis, leaving veterans vulnerable to addiction, divorce, homelessness, mental illness, incarceration, or suicide. The Veterans' Disability Benefits Commission hopes its work will ensure that all veterans are equitably and appropriately compensated for the sacrifices they made for their country.

The Commission completed its deliberations while American service members were protecting our national interests across the globe. Service members were wounded and dying in Iraq and Afghanistan while fighting the Global War on Terror. Many of us Commissioners have our own memories of combat and military experiences that guide us as we watch a new generation of troops engaged in war. We also have drawn insights from our civilian careers and civic responsibilities. We have the opportunity to welcome home today's service members by ensuring that the benefits and services available to them are the right ones and that they are being properly applied in a timely and appropriate manner.

As we submit this report, it is our hope that we have identified the key ingredients for successful transition from military service, for overcoming disability, and for achieving a level of benefits and services that enables veterans to live healthy, happy, productive lives in the civilian sector. The expeditious implementation of the recommendations made on the following pages by the responsible branches of government with the support of the veterans service organizations should give future generations of veterans a message that says, "Welcome home!"

Abbreviations

A & A: aid and attendance

ADLs: activities of daily living

AHLTA: Armed Forces Health Longitudinal Technology Application

ANPRM: Advanced Notice of Proposed Rulemaking

AO: Agent Orange

ATSDR: Agency for Toxic Substance and Disease Registry

BDD: Benefits Delivery at Discharge

BEC: Benefits Executive Council

BHIE: Bidirectional Health Information Exchange

BVA: Board of Veterans Appeals

C&P: compensation and pension

CACO: Casualty Affairs Casualty Officer

CAPRI: VBA's Compensation and Pension Records Initiative

CAVC: Court of Appeals for Veterans Claims

CBO: Congressional Budget Office

CBHCO: Army Community Based Health Care Organization

CHAMPUS: Civilian Health and Medical Program of the Uniformed Services

CHAMPVA: Civilian Health and Medical Program of VA

CHDR: Clinical Health Data Repository

CNAC: The CNA Corporation

COLA: cost of living adjustment

COOL: Credentialing Opportunities On-Line

CPEP: Compensation and Pension Examination Program

CPRS: VA's Computerized Patient Record System

CPS: current population survey

CRDP: Concurrent Retirement Disability Payments

CRSC: combat-related special compensation

CT: computed tomography

CVA: Court of Veterans Appeals

DES: Disability Evaluation System

DIC: dependency and indemnity compensation

DoD: Department of Defense

DOEHRS: Defense Occupational and Environmental Health Readiness System

DoL: Department of Labor

DOL-VETS: Department of Labor Veterans Employment and Training Service

DRO: Decision Review Officer

DSM: Diagnostic and Statistical Manual of Mental Disorders

DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition

DTAP: Disabled Transition Assistance Program

DU: depleted uranium

ECVARS: Economic Validation of the Rating Schedule

FHIE: Federal Health Information Exchange

GAO: Government Accountability Office

GWOT: Global War on Terrorism

HEC: Health Executive Council

HHS: Department of Health and Human Services

HIPAA: Health Insurance Portability & Accountability Act of 1996 (PL 104-191)

HRQOL: health-related quality of life

IADLs: instrumental activities of daily living

ICD-10: International Classification of Diseases, Tenth Revision

IED: improvised explosive device

IOM: Institute of Medicine

IT: information technology

IU: Individual Unemployability

JEC: Joint Executive Council

JEHRI: Joint Electronic Health Records Interoperability Plan

JIF: VA/DoD Joint Incentive Fund

LDSI: Laboratory Data Sharing and Interoperability software

LOD: line of duty

MCS: Mental Component Summary

MEB: Medical Evaluation Board

MIA: missing in action

MOS: military occupational specialty

MRI: Magnetic Resonance Imaging

MSA: Military Sexual Assault

MSIC: Military Severely Injured Center

MTF: military treatment facility

NDAA: National Defense Authorization Act

NPRM: Notice of Proposed Rulemaking

OEF: Operation Enduring Freedom

OIF: Operation Iraqi Freedom

OIG: Office of the Inspector General (VA)

PCB: polychlorinated biphenyls

PCCWW: President's Commission on Care for America's Returning Wounded Warriors

PCS: Physical Component Summary

PDRL: Permanent Disability Retired List

PEB: Physical Evaluation Board

PDHA: Post-Deployment Health Assessments

PDT: postdetermination team

POW: prisoner of war

PPDHA: pre- and post-deployment health assessments

PTSD: posttraumatic stress disorder

QOL: quality of life

RO: regional office

RVSR: rating veterans service representative

SAH: specially adapted housing

SBP: Survivor Benefit Plan

SDVI: Service-Disabled Veterans' Insurance

SHA: special housing adaptation

SIMS: Severely Injured Marines and Sailors pilot study

SMC: special monthly compensation

SSA: Social Security Administration

SSDI: Social Security Disability Insurance

STAR: Systematic Technical Accuracy Review

TAP: Transition Assistance Program

TBI: traumatic brain injury

TCE: Trichloroethylene

TDRL: temporary disability retired list

TMC: The Military Coalition

TRAAP: Temporary Residence Assistance Adaptation Program

TSGLI: Traumatic Servicemembers Group Life Insurance

VA: Department of Veterans Affairs

VASRD: VA Schedule for Rating Disabilities

VBA: Veterans Benefits Administration

VCAA: Veterans Claims Assistance Act

VCAC: Veterans Claims Adjudication Commission

VMET: Verification of Military Experience and Training

VETS: Veterans Employment and Training Service

VISN: Veterans Integrated Service Networks

VHA: Veterans Health Administration

VISN: Veteran Integration Service Network

VISTA: Veterans Health Information Systems and Technology Architecture

VJRA: Veterans Judicial Review Act

VMLI: Veterans Mortgage Life Insurance

VR&E: vocational rehabilitation and employment

VSO: veteran service organization

VSR: veterans service representative

Executive Summary

The Veterans' Disability Benefits Commission was established by Public Law 108-136, the National Defense Authorization Act of 2004. Between May 2005 and October 2007, the Commission conducted an in-depth analysis of the benefits and services available to veterans, service members, their survivors, and their families to compensate and provide assistance for the effects of disabilities and deaths attributable to military service. The Department of Veterans Affairs (VA) expended \$40.5 billion on the wide array of these benefits and services in fiscal year 2006. The Commission addressed the appropriateness and purpose of benefits, benefit levels and payment rates, and the processes and procedures used to determine eligibility. The Commission reviewed past studies on these subjects, the legislative history of the benefit programs, and related issues that have been debated repeatedly over many decades.

Congress created the Commission out of concern for a variety of issues pertinent to disabled veterans, disabled service members, their survivors, and their families. Those matters included care for severely injured service members, treatment and compensation for posttraumatic stress disorder (PTSD), the concurrent receipt of military retired pay and disability compensation, the timeliness of processing disabled veterans' claims for benefits, and the size of the backlog of those claims. Another area of concern was the program known as Individual Unemployability, which allows veterans with severe service-connected disabilities to receive benefits at the highest possible rate if their disabilities prevent them from working. The Commission gave these issues special attention.

The Commission received extensive analytical support from the CNA Corporation (CNAC), a well-known research and consulting organization. CNAC performed an in-depth economic analysis of the average impairment of earning capacity resulting from service-connected disabilities. In addition, to assess the impact of disabilities and deaths on quality of life, CNAC conducted surveys of disabled veterans and survivors. To gain insight into claims processing issues, CNAC surveyed raters from VA and representatives of veterans' service organizations who assist veterans in filing claims. CNAC also completed a literature review

and a comparative analysis of disability programs similar to those provided by VA.

The Commission received expert medical advice from the Institute of Medicine (IOM) of the National Academies. Required by statute to consult with IOM, the Commission asked the institute to conduct a thorough analysis of the VA Schedule for Rating Disabilities (hereafter the Rating Schedule) and a study of the processes used to decide whether one may presume that a disability is connected to military service. In addition, the Commission examined two studies that IOM conducted for VA about the diagnosis of PTSD and compensation to veterans for that disorder. Unfortunately, a third IOM study—of the treatment of PTSD—was not completed in time to be considered by the Commission. Additionally, the Commission conducted eight field visits and held numerous public sessions.

Guiding Principles

The Commission wrestled with philosophical and moral questions about how a nation cares for disabled veterans and their survivors and how it expresses its gratitude for their sacrifices. The Commission agreed that the United States has a solemn obligation, expressed so eloquently by President Lincoln, “to care for him who shall have borne the battle, and for his widow, and his orphan....”¹

In going about its work, the Commission has been mindful of the 1956 Bradley Commission principles, which have provided a valuable and historic baseline. This Commission’s report addresses what has changed and what has endured over those five decades and throughout our Nation’s wars and conflicts since the Bradley report. Many of the changes—social, technological, cultural, medical, and economic—that have taken place during that time span are significant and must be carefully considered as our Nation renews its compact with our disabled veterans and their families. This long-term context, a history of both significant change and key elements of constancy from the 1950s to the 21st century, provides the solid basis for this Commission’s principles, conclusions, and recommendations.

This Commission identified eight principles that it believes should guide the development and delivery of future benefits for veterans and their families:

1. *Benefits should recognize the often enormous sacrifices of military service as a continuing cost of war, and commend military service as the highest obligation of citizenship.*
2. *The goal of disability benefits should be rehabilitation and reintegration into civilian life to the maximum extent possible and preservation of the veterans’ dignity.*

¹ Lincoln, Abraham, *Second Inaugural Address*, March 4, 1865, <http://www.ourdocuments.gov/doc.php?flash=true&doc=38>.

3. *Benefits should be uniformly based on severity of service-connected disability without regard to the circumstances of the disability (wartime v. peacetime, combat v. training, or geographical location.)*
4. *Benefits and services should be provided that collectively compensate for the consequence of service-connected disability on the average impairment of earnings capacity, the ability to engage in usual life activities, and quality of life.*
5. *Benefits and standards for determining benefits should be updated or adapted frequently based on changes in the economic and social impact of disability and impairment, advances in medical knowledge and technology, and the evolving nature of warfare and military service.*
6. *Benefits should include access to a full range of health care provided at no cost to service-disabled veterans. Priority for care must be based on service connection and degree of disability.*
7. *Funding and resources to adequately meet the needs of service-disabled veterans and their families must be fully provided while being aware of the burden on current and future generations.*
8. *Benefits to our Nation's service-disabled veterans must be delivered in a consistent, fair, equitable, and timely manner.*

With these principles clearly in mind, the Nation must set the firm foundation upon which to shape and evolve a system of appropriate—and generous—benefits for the disabled veterans of tomorrow.

The Commission believes that just as citizens have a duty to serve in the military, the Federal Government has a duty to preserve the well-being and dignity of disabled veterans by facilitating their rehabilitation and reintegration into civilian life. The Commission believes that compensation should be based on the nature and severity of disability, not whether the disability occurred during wartime, combat, training, or overseas. It is virtually impossible to accurately determine a disease's origin or to differentiate the value of sacrifice among veterans whose disabilities are of similar type and severity. Setting different rates of compensation for the same degree of severity would be both impractical and inequitable.

Disabled veterans require a range of services and benefits, including compensation, health care, specially adapted housing and vehicles, insurance, and other services tailored to their special needs. Compensation must help service-disabled veterans achieve parity in earnings with nonservice-disabled veterans. Compensation must also address the impact of disability on quality of life. Money alone is a poor substitute for the consequences of the injuries and disabilities faced by veterans, but it is essential to ease the burdens they experience.

It is the duty of Congress and VA to ensure that the benefits and services for disabled veterans and survivors are adequate and meet their intended outcomes. IOM concluded that the VA Rating Schedule has not been adequately revised since 1945. This situation should **not** be allowed to continue. Systematic updates to the Rating Schedule and assessments of the appropriateness of the level of benefits should be made on a frequent basis.

Excellent health care should be provided in a timely manner at no cost to veterans with service-connected disabilities (i.e., service-disabled veterans) and, in the case of severely injured veterans, to their families and caregivers.

The funding and resources necessary to fully support programs for service-disabled veterans must be sufficient while ensuring that the burden on the Nation is reasonable. Care and benefits for service-disabled veterans are a cost of maintaining a military force during peacetime and of fighting wars. Benefits and services must be provided promptly and equitably.

Results of the Commission's Analysis

The analyses conducted by the Commission with the assistance of IOM and CNAC provide a consistent and complementary picture of many aspects of veterans' disability compensation.

Ensure Horizontal and Vertical Equity

For veterans to receive proper compensation for their service-connected disabilities, the VA Rating Schedule must be designed so that ratings result in horizontal and vertical equity in terms of compensation for average impairments of earning capacity. Horizontal equity means that persons with the same ratings percentage should have experienced the same loss of earning capacity. Vertical equity means that loss of earning capacity should increase in proportion to an increase in the degree of disability. A comparison of the earnings of disabled veterans with those of veterans who lacked service-connected disabilities revealed that the average amount of earnings lost by disabled veterans generally increased as disability ratings increased. In addition, mortality rates rose with degree of disability. Thus, vertical equity is achieved. The average earnings loss was similar across different types of disabilities except for PTSD and other mental disorders, indicating that horizontal equity also is generally being achieved at the level of body systems.

Ensure Parity with Nondisabled Veterans

Overall, disabled veterans who first apply to VA for compensation at age 55 (the average age) receive amounts of money that are nearly equal to their average loss of earnings as a consequence of their disabilities among the broad spectrum of physical disabilities.

The earnings of a representative sample of nondisabled veterans were compared with the sum of earnings plus compensation of disabled veterans to determine the extent to which disability compensation helps disabled veterans achieve parity with their nondisabled counterparts. Among veterans whose primary disabilities are physical, those who are granted Individual Unemployability are substantially below parity; those who are rated 100 percent disabled and who enter the system at a younger age (45 years or less) are slightly below parity; and those who enter at age 65 or older are above parity. For those whose primary disabilities are mental, the sum of earnings plus VA compensation is generally below parity at average age of entry, substantially below parity for severely disabled individuals who enter the system at a younger age, and above parity for those who enter at age 65 or older. Also, among veterans whose primary disabilities are mental, those rated 10 percent disabled are slightly below parity. Thus, parity is generally present with respect to earnings loss except among individuals whose primary disabilities are mental, among the younger severely disabled, and among those granted Individual Unemployability.

Compensate for Loss of Quality of Life

Parity in average loss of earnings means that disability compensation does not compensate veterans for the adverse impact of their disabilities on quality of life.

Current law requires only that the VA Rating Schedule compensate service-disabled veterans for average impairment of earning capacity. However, the Commission concluded early in its deliberations that VA disability compensation should recompense veterans not only for average impairments of earning capacity, but also for their inability to participate in usual life activities and for the impact of their disabilities on quality of life. IOM reached the same conclusion; moreover, it made extensive recommendations on steps to develop and implement a methodology to evaluate the impact of disabilities on veterans' quality of life and to provide appropriate compensation.

The Commission concluded that the VA Rating Schedule should be revised to include compensation for the impact of service-connected disabilities on quality of life. For some veterans, quality of life is addressed in a limited fashion by special monthly compensation for loss of limbs or loss of use of limbs. Some ancillary benefits attempt to ameliorate the impact of disability. However, the Commission urges Congress to consider increases in some special monthly compensation awards to address the profound impact of certain disabilities on quality of life and to assess whether other ancillary benefits might be appropriate. While a recommended systematic methodology is developed for evaluating and compensating for the impact of disability on quality of life, the Commission believes that an immediate interim increase of up to 25 percent of compensation should be enacted.

A survey of a representative sample of disabled veterans and survivors was conducted to assess their quality of life and other issues. The survey found that

among veterans whose primary disability is physical, their physical health is inferior to that of the general population for all levels of disability, and their physical health generally worsens as their level of disability increases. Physical disabilities did not lead to decreased mental health. For veterans whose primary disability is mental, not only were their mental health scores much lower than those of the general population, but their physical health scores were well below population norms for all levels of mental disability. Those veterans with PTSD had the lowest physical health scores.

The survey also sought to address two specific issues through indirect questions. There are concerns that service-disabled veterans tend not to follow medical treatments because they fear it might impact their disability benefits. This premise was not substantiated. Likewise, when questioned whether VA benefits created a disincentive to work, only 12 percent of respondents indicated they might work or work more if not for compensation benefits; thus, this is not a major issue.

Update the Rating Schedule

The Rating Schedule consists of slightly more than 700 diagnostic codes organized under 14 body systems, such as the musculoskeletal system, organs of special sense, and mental disorders. For each code, the schedule provides criteria for assigning a percentage rating. The criteria are primarily based on loss or loss of function of a body part or system, as verified by medical evidence; however, the criteria for mental disorders are based on the individual's "social and industrial inadaptability," meaning the overall ability to function in the workplace and everyday life.

IOM concluded that it has been 62 years since the VA Rating Schedule was adequately revised and made a series of recommendations for immediately updating the Rating Schedule and requiring that it be revised on a systematic and frequent basis. The Commission generally agrees with these recommendations; however, the Commission does not agree that the revision should begin with those body systems that have not been revised for the longest time period. Rather, the Commission recommends that first priority be given to revising the mental health and neurological body systems to expeditiously address PTSD, other mental disorders, and traumatic brain injury. A quick review by VA of the Rating Schedule could be completed to determine the sequence in which the other body systems should be addressed, and a timeline should be developed for completing the revision.

To emphasize the importance and urgency of revising the Rating Schedule, the Commission urges Congress to require that the entire schedule be reviewed and updated as needed over the next 5 years. Congress should monitor progress carefully. Thereafter, the Rating Schedule should be reviewed and updated on a frequent basis.

Individual Unemployability

The Individual Unemployability (IU) program enables a veteran rated 60 percent or more but less than 100 percent to receive benefits at the 100 percent rate if he or she is unable to work because of service-connected disabilities. IU has received considerable attention recently because the number of veterans granted IU increased by 90 percent. The Commission found this increase to be explained by the aging of the cohort of Vietnam veterans.

Develop PTSD-Specific Rating Criteria and Improve PTSD Treatment

Concerning PTSD and other mental disorders, it is very clear that having one set of criteria for rating all mental disorders has been ineffective. IOM recommended separate criteria for PTSD. Similarly, the CNAC survey of VA raters found that raters believe separate criteria for PTSD would enable them to rate PTSD claims more effectively. In addition, the earnings analysis described above demonstrates that there is a disparity in earnings of those with PTSD and other mental disorders and that the current scheme for rating all mental disorders in five categories of severity—10, 30, 50, 70, and 100 percent—does not result in adequate compensation. It is also unclear why 31 percent of those with PTSD as their primary diagnosis are granted IU, especially since incapacity to work is part of the current criteria for granting 100 percent for PTSD and other mental disorders. It would seem that many of these veterans should be awarded 100 percent ratings without IU. The Commission agrees with the IOM recommendation that new Rating Schedule criteria specific to PTSD should be developed and implemented based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders*.

The Commission believes that a new, holistic approach to PTSD should be considered. This approach should couple PTSD treatment, compensation, and vocational assessment. The Commission believes that PTSD is treatable, that it frequently recurs and remits, and that veterans with PTSD would be better served by a new approach to their care. There is little interaction between the Veterans Health Administration, which examines veterans for evaluation of severity of symptoms and treats veterans with PTSD, and the Veterans Benefits Administration, which assigns disability ratings and may or may not require periodic reexamination. It is evident that PTSD reexaminations have been scheduled with less frequency in recent years due to the backlog of disability claims. It is also evident that case management of PTSD patients could be improved through greater interaction between the therapy received in Vet Centers and treatment in VA medical centers. IOM concluded that the use of standardized testing and the frequency of reexaminations should be recommended by clinicians on a case-by-case basis, but did not suggest how that would be achieved. The Commission suggests that treatment should be required and its effectiveness assessed to promote wellness of the veteran. Reexaminations should be scheduled and conducted every 2 to 3 years.

Improve Performance of Vocational Rehabilitation and Employment

The Commission believes that the goal of disability benefits, as expressed in guiding principle 2, is not being met. In spite of the studies done and recommendations made in recent years, the Vocational Rehabilitation and Employment (VR&E) program is not accomplishing its primary goal. The Commission believes that recent studies have provided the necessary analyses and that VA possesses the necessary expertise to remedy this failure. Simply put, VA must develop specific plans and Congress must provide the resources to quickly elevate the performance of VR&E.

Allow Concurrent Receipt

The Commission carefully reviewed whether disabled veterans should be permitted to receive both military retirement benefits and VA disability compensation. The Commission also reviewed whether the survivors of veterans who die either on active duty or as a result of a service-connected disability should be allowed to receive both Department of Defense (DoD) Survivor Benefit Plan (SBP) and VA Dependency and Indemnity Compensation (DIC). Currently, military retirees with service-connected disabilities rated 50 percent or higher are authorized to receive both benefits, which are being phased in over the next few years. Survivors are not authorized to receive both benefits. The Commission is persuaded that these programs have unique intents and purposes: military retirement benefits and SBP are intended to compensate for years of service, while VA disability compensation and DIC are intended to compensate for disability or death attributable to military service. It should be permissible to receive both sets of benefits concurrently.

In addition, the Commission believes that those separated as medically unfit with less than 20 years of service should also be able to receive military retirement and VA compensation without offset. Currently, those receiving ratings of less than 30 percent from DoD receive separation pay, which must be paid back through deductions from VA compensation for the unfitting conditions before VA compensation is received. Those receiving DoD ratings of 30 percent or higher and a continuing disability retirement have their DoD payments offset by any VA compensation. Priority among medical discharges should be given to those separated or retired with less than 20 years of service and disability rating greater than 50 percent or disability as a result of combat.

Allow Young, Severely Injured Veterans to Receive Social Security Disability Insurance

Among the benefits available for disabled veterans, those not able to work may be eligible for Social Security Disability Insurance (SSDI). To be eligible for SSDI, an individual must have worked a minimum number of quarters, be unable to work because of medical conditions, not have income above a minimum level, and be less than 65 years of age. At 65, SSDI converts to normal Social Security at the same amount. Some very young service members who are severely

injured may not have sufficient quarters to qualify for SSDI. The Commission recommends eliminating the minimum quarters requirement for the severely injured. Only 61 percent of those granted IU by VA and 54 percent of those rated 100 percent by VA are receiving SSDI. Considering the very low earnings by those rated 100 percent and the exceptionally low earnings of those granted IU, it is apparent that either these veterans do not know to apply for SSDI or are being denied the insurance. Increased outreach should be made and better coordination between VA and Social Security should result in increased mutual acceptance of decisions.

Realign the VA-DoD Process for Rating Disabilities

The Commission also assessed the consistency of ratings by DoD and VA on individuals found unfit for military service by DoD under 10 U.S.C. chapter 61. Some 83,000 service members were found unfit between 2000 and 2006. DoD rated 81 percent of those individuals as less than 30 percent and discharged them with severance pay, including over 13,000 who were found unfit by the Army and given zero percent ratings. Seventy nine percent of these service members later filed claims with VA and received substantially higher ratings. The reasons for the higher ratings are that VA rates about three more conditions than DoD, and at the individual diagnosis level VA assigns higher ratings than DoD.

The Commission finds that the policies and procedures used by VA and DoD are not consistent and the resulting dual systems are not in the best interest of the injured service members nor the Nation. Existing practices that allow service members to be found unfit for preexisting conditions after up to 8 years of active duty and that allow DoD to rate only the conditions that DoD finds unfitting should be reexamined. Service members being considered unfit should be given a single, comprehensive examination and all identified conditions should be rated and compensated.

The Commission agrees with the President's Commission on the Care of Returning Wounded Warriors that the DoD and VA disability evaluation process should be realigned so that the military determines if the service member is unfit for service and awards continuing payment for years of service and health care coverage for the family while VA pays disability compensation. However, in accordance with one of our key guiding principles, the Commission believes that benefits should not be limited to combat and combat-related injuries. Nor does the Commission believe that VA disability compensation should end and be replaced with Social Security at retirement age.

Link Benefits to Cost-of-Living Increases

In its review, the Commission found that the ancillary and special-purpose benefits payments and award limits are not automatically indexed to cost of living. A few of these benefits have not been increased in many years, and as a result, some no longer meet the original intent of Congress. The Commission

recommends that Congress raise ancillary and special-purpose benefits to the levels originally intended and provide for automatic annual adjustments to keep pace with the cost of living.

Simplify and Expedite the Processing of Disability Claims and Appeals

VA disability benefits and services are not currently provided in a timely manner. Court decisions, statutory changes, and resource limitations have all contributed to this unacceptable situation. Numerous studies over the years have assessed the processing of both claims and appeals and have made numerous recommendations for change. Still, veterans seeking disability compensation face a complex process. The population of veterans is steadily decreasing with the passing of veterans of World War II and the Korean War. Yet, the aging of the Vietnam Era veterans means that they are filing original and reopened claims in large numbers. Technology offers opportunities for improvement, but it is unlikely to solve all problems. The Commission believes that increased reliance on best business practices and maximum use of information technology should be coupled with a simplified and expedited process for well-documented claims to improve timeliness and reduce the backlog. The Commission is aware that a significant increase in claims processing staff has been recently approved but is also aware that the time required for training and the slow development of job experience will limit the speed with which results can realistically occur.

The Commission believes that claimants should be allowed to state that claim information submitted is complete and waive the normal 60-day time frame permitted for further development.

Improve Transition Assistance

A smooth transition from military to civilian status is crucial for veterans and their families to quickly adjust to civilian life. This goal, often expressed as “seamless transition,” has yet to be fully realized, although VA and DoD have made significant improvements during the past few years. The two departments’ medical and other systems are not truly compatible, and both departments will have to rely on paper records for many years. Perhaps the single most important step that can be taken to assist veterans, particularly those who are disabled and their families, and to reduce the lengthy delays plaguing claims processing would be to achieve electronic compatibility. In addition, the Commission believes that making VA benefit payments effective the day after discharge will help ease the financial aspect of transition.

Improve Support for Severely Disabled Veterans and their Caregivers

Severely disabled service members who are about to transition into civilian life need far more support and assistance than is currently provided. An effective case management program should be established with a clearly identified lead agent who has authority and responsibility to intercede on behalf of disabled

individuals. The lead agent should be an advocate for service members and their families. In addition, VA should be authorized to provide family assistance similar to that provided by DoD up until discharge. Tricare deductibles and copays are costs incurred by the severely disabled; the Commission believes that these costs should be waived. In addition, consideration should be given to expanding health care and providing an allowance for caregivers of the severely disabled. Currently, health care is only provided for the dependents of severely disabled veterans but not for parents and other family members who are caregivers.

Implement a New Process for Determining Presumption

Various processes have been used to create presumptions when there are uncertainties as to whether a disabling condition is caused by military service. Presumptions are established when there is evidence that a condition is experienced by a sufficient cohort of veterans and it is reasonable to presume that all veterans in that cohort who experience the condition acquired the condition due to military service. The Commission asked IOM to review the processes used in the past to establish presumptions and to recommend a framework that would rely on more scientific principles. IOM conducted an extensive analysis and recommended a detailed and comprehensive approach that includes the creation of an advisory committee and a scientific review board, formalizing the process and making it transparent, improving research, and tracking military troop locations and environmental exposures. Perhaps most importantly, the approach includes using a causal effect standard for decision making rather than a less-precise statistical association. The Commission endorses the recommendations of the IOM but expresses concern about the causal effect standard. Consideration should also be given to combining the advisory committee on presumptions with the recommended advisory committee on the Rating Schedule.

Conclusion

The Commission made 113 recommendations. All are important and should receive attention from Congress, DoD, and VA. The Commission suggests that the following recommendations receive immediate consideration. Congress should establish an executive oversight group to ensure timely and effective implementation of the Commission recommendations.

Priority Recommendations

Recommendation 4.23

Chapter 4, Section I.5

VA should immediately begin to update the current Rating Schedule, beginning with those body systems addressing the evaluation and rating of posttraumatic stress disorder and other mental disorders and of traumatic brain injury. Then proceed through the other body systems until the Rating Schedule has been

comprehensively revised. The revision process should be completed within 5 years. VA should create a system for keeping the Rating Schedule up to date, including a published schedule for revising each body system.

Recommendation 5.28

Chapter 5, Section III.3

VA should develop and implement new criteria specific to posttraumatic stress disorder in the VA Schedule for Rating Disabilities. VA should base those criteria on the *Diagnostic and Statistical Manual of Mental Disorders* and should consider a multidimensional framework for characterizing disability due to posttraumatic stress disorder.

Recommendation 5.30

Chapter 5, Section III.3

VA should establish a holistic approach that couples posttraumatic stress disorder treatment, compensation, and vocational assessment. Reevaluation should occur every 2–3 years to gauge treatment effectiveness and encourage wellness.

Recommendation 6.14

Chapter 6, Section IV.2

Congress should eliminate the ban on concurrent receipt for all military retirees and for all service members who separated from the military due to service-connected disabilities. In the future, priority should be given to veterans who separated or retired from the military under chapter 61 with

- fewer than 20 years service and a service-connected disability rating greater than 50 percent, or
- disability as a result of combat.

Recommendation 7.4

Chapter 7, Section II.3

Eligibility for Individual Unemployability (IU) should be consistently based on the impact of an individual's service-connected disabilities, in combination with education, employment history, and medical effects of an individual's age or potential employability. VA should implement a periodic and comprehensive evaluation of veterans eligible for IU. Authorize a gradual reduction in compensation for IU recipients who are able to return to substantially gainful employment rather than abruptly terminating disability payments at an arbitrary level of earning.

Recommendation 7.5

Chapter 7, Section II.3

Recognizing that Individual Unemployability (IU) is an attempt to accommodate individuals with multiple lesser ratings but who remain unable to work, the Commission recommends that as the VA Schedule for Rating Disabilities is revised, every effort should

be made to accommodate such individuals fairly within the basic rating system without the need for an IU rating.

Recommendation 7.6**Chapter 7, Section III.2**

Congress should increase the compensation rates up to 25 percent as an interim and baseline future benefit for loss of quality of life, pending development and implementation of a quality-of-life measure in the Rating Schedule. In particular, the measure should take into account the quality of life and other non-work-related effects of severe disabilities on veterans and family members.

Recommendation 7.8**Chapter 7, Section III.2**

Congress should consider increasing special monthly compensation, where appropriate, to address the more profound impact on quality of life of the disabilities subject to special monthly compensation. Congress should also review ancillary benefits to determine where additional benefits could improve disabled veterans' quality of life.

Recommendation 7.12**Chapter 7, Section VI**

VA and DoD should realign the disability evaluation process so that the services determine fitness for duty, and service members who are found unfit are referred to VA for disability rating. All conditions that are identified as part of a single, comprehensive medical examination should be rated and compensated.

Recommendation 7.13**Chapter 7, Section V.3**

Congress should enact legislation that brings ancillary and special-purpose benefits to the levels originally intended, considering the cost of living, and provides for automatic annual adjustments to keep pace with the cost of living.

Recommendation 8.2**Chapter 8, Section III.1.B**

Congress should eliminate the Survivor Benefit Plan/Dependency and Indemnity Compensation offset for survivors of retirees and in-service deaths.

Recommendation 9.1**Chapter 9, Section II.5.A.b**

Improve claims cycle time by

- establishing a simplified and expedited process for well-documented claims, using best business practices and maximum feasible use of information technology; and
- implementing an expedited process by which the claimant can state the claim information is complete and waive the time period (60 days) allowed for further development.

Congress should mandate and provide appropriate resources to reduce the VA claims backlog by 50 percent within 2 years.

Recommendation 10.11**Chapter 10, Section VII**

VA and DoD should expedite development and implementation of compatible information systems including a detailed project management plan that includes specific milestones and lead agency assignment.

Recommendation 11.1**Chapter 11**

Congress should establish an executive oversight group to ensure timely and effective implementation of the Commission's recommendations. This group should be cochaired by VA and DoD and consist of senior representatives from appropriate departments and agencies. It is further recommended that the Veterans' Affairs Committees hold hearings and require annual reports to measure and assess progress.

One commissioner submitted a statement of separate views regarding four aspects of the report. His statement is in Appendix L.

Introduction

As U.S. casualties began returning from combat in Iraq and Afghanistan, Congress debated long-standing issues regarding the most effective ways to deliver benefits and care to the Nation's veterans. To help resolve the many pressing and complex concerns about veterans' benefits, the President and Congress created this independent Commission under Public Law 108-136, The National Defense Authorization Act of 2004 (see Appendix A).

The first Commission of its kind in over 50 years, the Veterans' Disability Benefits Commission has 13 commissioners, whose biographies appear in Appendix B, and 19 staff. Five members of the Commission were appointed by the President. Two members each were appointed by the Speaker and the Minority Leader of the U.S. House of Representatives and the majority and minority leaders of the U.S. Senate. Because the Federal Advisory Committee Act requires transparency in the Commission's deliberations, all decisions have been made in a public forum and are a matter of public record.

I Commission's Charter and Scope of Work

The purpose of the Veterans' Disability Benefits Commission is to study the benefits and services available to U.S. veterans and their dependents and survivors to compensate for and assist with disabilities and deaths attributable to military service. Specifically, the Commission's charter directed the group to evaluate and assess

- the appropriateness of the benefits,

- the appropriateness of the level of benefits, and
- the standards for determining eligibility for benefits.

Also, the Commission was granted the authority to examine any related issues that it deemed relevant to the purposes of the study.

II Methodology

II.1 Commission Analyses

Issues of interest to the veteran community have come to the attention of the Commission in many ways. Some have been presented by interested members of the public, at public meetings either in Washington, DC, or at eight dispersed locations the Commission visited. Many of these issues were identified from previous studies, largely from the Government Accountability Office (GAO), or reports of other commissions or from the Commissioners themselves. These issues are discussed throughout the chapters of the report. The Commission structured its analysis by developing 31 research questions, which appear in Appendix C. The Commission staff drafted 11 white papers that analyzed 16 of those questions and presented options to the Commission to deliberate. The white papers covered the following subjects:

- Lump sum payments
- Concurrent receipt
- Survivor concurrent receipt
- Line of duty
- Character of discharge
- Pending claim ends with death
- Time limit to file
- Age as a factor
- Apportionment and garnishment
- Vocational rehabilitation and employment
- Transition

Attorneys conducted legal analyses of several of these issues and gave the Commission an in-depth historical context for much of the legislation that

currently affects the benefits available to disabled veterans, their families, and survivors.

II.2 Site Visits

In addition, the Commission collected information by conducting a series of eight site visits to Tampa/St. Petersburg, Florida; San Antonio, Texas; Chicago, Illinois; St. Louis, Missouri; San Diego, California; Seattle, Washington; Boston, Massachusetts; and Atlanta, Georgia. Each of these site visits included a town hall meeting with local veterans and extensive meetings with representatives of veteran service organizations, state departments of veterans affairs, and officials and staff at VA regional offices and medical centers and military installations. These visits brought the Commissioners in direct contact with disabled veterans, family members, transitioning service members, and those who deliver benefits and services to them. The focus of the official visits was the disability evaluation processes within VA and DoD and issues related to the transition of service members from active duty to civilian life. The Commission also examined the nature of communication and outreach from VA and DoD to veterans and their families and between the two departments. Appendix D is a consolidated summary of these site visits.

II.3 Consultation with the Institute of Medicine

Part of the Commission's founding legislation required consultation with the Institute of Medicine (IOM) to review the medical aspects of the VA disability compensation procedures and programs. To accomplish this goal and to address additional research questions, the Commission contracted with IOM. The Commission also gleaned information from two studies on posttraumatic stress disorder (PTSD) that IOM conducted on behalf of the Veterans Health Administration (VHA).

IOM established several committees to answer the statements of work presented to it. These committees included the following:

- Medical Evaluation of Veterans for Disability Compensation
- Evaluation of the Presumptive Decision-Making Process for Veterans
- Veterans' Compensation for Posttraumatic Stress Disorder
- Posttraumatic Stress Disorder (PTSD): Diagnosis and Assessment

- PTSD Treatment (at the time of this report release, the third VHA contract with IOM on PTSD Treatment is incomplete and not available for inclusion)

The Commission tasked the IOM Committee on Medical Evaluation of Veterans for Disability Compensation to study the VA Schedule for Rating Disabilities (Rating Schedule) to determine whether the schedule is an appropriate, valid, and reliable instrument for evaluating impairment, rating degree of disability, and compensating disabled veterans for the impact on quality of life and impairments of earning capacity. The IOM committee compared the Rating Schedule to other modern diagnostic techniques and considered whether the schedule is based on the most current scientific evidence. This expert panel also looked at methods for assessing the severity of single and multiple conditions, as well as secondary and aggravated service-connected conditions. The committee's final report also included an evaluation of the current use of Individual Unemployability (IU) as a supplemental rating tool in lieu of rating criteria that might more accurately reflect a veteran's ability to participate in the economic marketplace.

The Commission charged the IOM Committee on the Evaluation of the Presumptive Decision-Making Process for Veterans to conduct a comprehensive review of the historical and current methodologies used to identify diseases associated with the environmental and occupational hazards of military service. Since 1921, many decisions have been rendered to presumptively grant service connection to numerous categories of diseases. Often, these decisions are made by the VA Secretary or by Congress based on limited or even conflicting information. The IOM Presumption Committee was asked to assess the current process and propose improvements, including a more scientific approach, such as an epidemiological model, that could be used to support future decisions.

VHA contracted with IOM to study and report on several aspects of PTSD in relation to military service, and the Commission evaluated two of the resulting reports. One of these reports, *PTSD Compensation and Military Service*, examined VA's methodology for rating and compensating veterans diagnosed with PTSD. The authoring committee reviewed the Rating Schedule criteria used to determine the level of severity of disability, taking into account how changes in frequency and intensity of symptoms might affect ratings and compensation. The committee considered how periods of remission and return of symptoms compare with other chronic conditions, both in practice and reevaluation requirements. Strategies used to support recovery, return to function, and possibly work for patients with PTSD also factored into the committee's approach to evaluating how veterans with PTSD are compensated.

The second IOM report on PTSD that the Commission examined was *Posttraumatic Stress Disorder: Diagnosis and Assessment*. The committee that authored this report conducted a review of the scientific and medical literature on PTSD and provided a foundation for discussing the characteristics of PTSD and known risk factors. This committee also commented on current diagnostic criteria and the validity of assessment instruments, concluding with a recommended approach to screening veterans for PTSD.

IOM accomplished these tasks by conducting literature reviews, inviting expert witnesses, hearing veteran and other stakeholders' testimony, and through its deliberations. IOM, as part of the National Academies of Science, has a peer-review protocol, and its reports are available to the general public.

II.4 Consultation with the CNA Corporation

The Commission also examined the results of studies undertaken on its behalf by the CNA Corporation (CNAC). Some of these studies were literature reviews on quality of life, earnings capacity, Individual Unemployability, and lump sum payments. Additionally, CNAC surveyed VA raters, service officers from veteran service organizations, and disabled veterans and survivors. These surveys were scientifically valid and reliable. A random sample methodology was used for the veterans and survivor surveys. VA, DoD, the Office of Personnel Management, and the Social Security Administration provided data for matches and subsequent analysis by CNAC.

II.5 Commission Meetings

The Commission also gathered information through its 28 public sessions, which consumed 55 days over more than 2 years. During those sessions, the Commission heard from subject-matter experts, federal and state officials, military and veteran service organizations, researchers, contractors, the public, and other stakeholders. VA, DoD, and specific federal administrations and agencies covered a broad range of topics during their briefings, including seamless transition, the VA rating process, the DoD disability evaluation system, certification, environmental hazards and exposures, severely injured programs and treatment, Social Security Disability Insurance, and employment. Additional information reached the Commission in the form of letters, faxes, phone calls, and nearly 4,000 e-mails.

III Definitions of Disability

As part of its initial investigative work, the Commission—along with IOM—studied various definitions of *disability* to develop parameters for terms and concepts used by the medical community to understand the differences between impairment, handicap, and disability. VA does not have an explicit definition of disability, but does codify functional impairment as follows:

The basis of disability evaluations is the ability of the body as a whole or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment...lack of usefulness of these parts or systems, especially in self-support (38 C.F.R. § 4.10 [2006]).

The VA disability rating “is based upon the average impairment in earning capacity, that is, upon the economic or industrial handicap which must be overcome and not from individual success in overcoming it” (38 C.F.R. § 4.15 [2006]).

To further its understanding, the Commission turned to the World Health Organization (WHO), which makes clear distinctions between impairment, disability, and handicap. WHO defines impairment as, “the loss of physiological integrity in a body function or anatomical integrity in a body structure; caused by disease, injury, or congenital defect.”¹ Therefore, the term *impairment*, for example, can be applied to the inability to move the leg at the joint, which may worsen over time without treatment.

The term *handicap* connotes a disadvantage for a given individual resulting from an impairment or a disability that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual. However, *handicap* is regarded by the disability community as “possessing negative connotations that are inconsistent with current views on disability and its meaning in the Americans with Disabilities Act (ADA)” of 1990 (Pub. L. 101-336, [1990]).² Thus, the Commission did not consider this concept further.

¹ WHO, *International Classification*, 2001.

² ADA prohibits discrimination on the basis of disability. Provisions of the act became effective at various times ranging from 30 days to 30 years after the law was passed. In general it became effective on July 26, 1992.

The WHO definition of disability is any restriction or lack of ability (resulting from impairment) to perform an activity in the manner or within the range considered normal for a human being.³ IOM viewed disability as a “broad term” and saw the disabling process as having four domains: pathology, impairment, functional limitation, and disability and includes mediating factors (i.e. lifestyle and environment), which impact quality of life.⁴ Therefore, disability, unlike impairment, would denote an inability to walk, which may be overcome with physical therapy or special equipment. Thus, a person may have an impairment that does not necessarily create a disability if the impairment can be treated or corrected using therapy or special equipment.

The definition of disability underlying the CNAC analyses for the Commission related disability to military service and rating of severity by VA. According to CNAC:

A disability is defined as either an injury or a disease that resulted from service or a preexisting injury or disease that was aggravated by service. A veteran can have multiple disabilities, each of which is assigned a rating reflecting its severity. The combination of the disability ratings for all disabilities determines a veteran’s level of compensation.⁵

IV Definition of Quality of Life

Throughout the Commission’s 30 months of discussions and deliberations about disability benefits and compensation policies, quality of life remained a central concept. Several of the Commission’s guiding principles reflect this sentiment both implicitly and explicitly. Findings and recommendations from IOM and CNAC also consider quality of life to be integral to discussions of disability.

In 1993, WHO put forward a definition of *quality of life* linked to health:

the perception by individuals of their position in life, in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.⁶

³ WHO, *International Classification*, 1980.

⁴ Institute of Medicine (IOM), *21st Century System*, 72.

⁵ CNAC, *Final Report*, 133.

⁶ WHO, “Quality of Life,” 153–159.

This definition is the basis for IOM's usage of the term *quality of life* in the report *A 21st Century System for Evaluating Veterans for Disability Benefits*. IOM's usage considers several dimensions of a person's life and reflects changes over time.⁷ The report also uses the term *health-related quality of life*, which measures "what an individual values and whether there is much satisfaction in one's life."⁸ Chapter 3 of *A 21st Century System for Evaluating Veterans for Disability Benefits* is entirely dedicated to impairment, disability, and quality of life; the definitions of these terms include such mediating factors as lifestyle and aspects of behavior, biology, and environment. "By definition, the concept of quality of life covers many dimensions of one's life: cultural, psychological, physical, interpersonal, spiritual, financial, political, temporal, and philosophical,"⁹ wrote the IOM Committee on Medical Evaluation of Veterans for Disability Compensation. The group also observed the need to integrate quality of life into clinical assessments:

In general, the health care establishment is committed to helping reduce the burden of disease, but has become increasingly aware of patient priorities, which include the desire to be independent, to maintain valued activities, and to have a sense of well-being in all aspects of daily life—in short, to achieve a good quality of life. The Centers for Disease Control and Prevention (CDC) defines quality of life as the perception of physical and mental health over time.¹⁰

In chapter 4 of this report, the Commission endorses IOM's recommendation to compensate disabled veterans for three consequences of service-connected injuries and disease: work disability, loss of ability to engage in usual life activities other than work, and loss of quality of life. Chapter 7 presents the results of CNAC's surveys on veterans' quality of life and contains a discussion of the subject.

V Other U.S. Government Comparisons

During its exploration of different employee benefit programs similar to VA benefits, the Commission looked at the programs for disabled employees offered by other federal, state, and local governments. CNAC and GAO comparisons on public safety officers were reviewed. The Commission found there was a great deal of variance in how these benefits were defined and delivered.

⁷ IOM, *21st Century System*, 72.

⁸ *Ibid.*

⁹ IOM, *21st Century System*, 59.

¹⁰ *Ibid.*, 67.

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- WHO, "Quality of Life Assessment Instrument (WHOQOL)," in *Quality of Life Research*, Geneva, Switzerland: WHO, 1993, 153–159.

Guiding Principles

Throughout their deliberations, the Commissioners carefully considered the philosophical and moral questions of how a grateful Nation shows appreciation for and takes care of its disabled veterans and their families. Indeed, the Commission believes that it is a moral obligation of the Nation to give its veterans appreciation and care in the most effective manner possible.

In developing its guiding principles, the Commission looked to the past—particularly the work of previous commissions, task forces, and study groups—to identify common themes and ideals. The work of the Bradley Commission of 1956 was particularly compelling. Formally called the Commission on Veterans' Pensions, the group created nine guidelines for veterans' benefits and hoped its work, with continued research, would “lead to a more equitable and rational system of veterans' benefits—one adjusted to the real needs of veterans on the one hand, and to the requirements of a healthy overall economy on the other

hand.”¹ This Commission agrees with the Bradley Commission’s vision and seeks to advance similar goals.

The following principles should underpin the policies and practices of veterans’ disability benefits now and in the future. The Commission believes these are the principles that should guide Congress, the Department of Veterans Affairs, and the Department of Defense as they face the difficult challenges of effectively shaping and evolving the benefits system for the nation’s present and future disabled veterans.

Principle 1

Benefits should recognize the often enormous sacrifices of military service as a continuing cost of war, and commend military service as the highest obligation of citizenship.

This principle recognizes and honors the American tradition of military service as a citizen’s duty. Americans know that freedom is not free. This country has paid each war’s veterans and survivors their due benefits for as long as 150 years after the armed conflict. Such expenditures must be included in calculations of the cost of war to ensure the availability of sufficient funds to care for future generations of disabled veterans.

Preserving the dignity and integrity of military service is a paramount obligation of the Federal Government. If veterans’ benefits are insufficient to care for those who have “borne the battle,” this may diminish America’s ability to recruit and retain Armed Forces personnel, potentially compromising national security.

¹ President’s Commission on Veterans’ Pensions (“Bradley Commission”), *Findings and Recommendations: Veterans Benefits in the United States*, Washington, DC: House Committee on Veterans Affairs, 1956, 32.

Principle 2

The goal of disability benefits should be rehabilitation and reintegration into civilian life to the maximum extent possible while preserving the veterans' dignity.

The government must help wounded warriors reestablish themselves physically, psychologically, and professionally in civilian society. To that end, disabled veterans should have access to state-of-the-art rehabilitative care, to social services, and to funds that help veterans accommodate to living with disabilities. Disability benefits should assist veterans in the most effective manner to attain their maximum level of functioning. Disability benefits must achieve this goal to give disabled veterans the opportunity for "life, liberty, and the pursuit of happiness."

Principle 3

Benefits should be uniformly based on severity of service-connected disability without regard to the circumstances of the disability (wartime v. peacetime, combat v. training, or geographical location).

Military service is a 24-hour responsibility from induction to discharge. A disabling injury or illness sustained at any time or place during military service is a sacrifice to the Nation and a source of suffering to the affected individual and his or her family. Thus, all disability-causing illnesses and injuries that occur during a period of military service that is other than dishonorable must be compensated. The level of compensation should be commensurate with the severity of the disability.

Principle 4

Benefits and services should be provided that collectively compensate for the consequences of service-connected disability on the average impairment of earning capacity, the ability to engage in usual life activities, and quality of life.

The current statutory basis for veterans' disability payments is the average impairment of earning capacity, yet service-connected disabilities can impede veterans from engaging in usual life activities and can impair their quality of life. A fair package of disability benefits and services must provide care for and compensate for veterans' impairments, impediments to usual daily functioning, and loss of quality of life. The compensation levels for disabled veterans should be assessed in comparison with the earnings of nondisabled veterans on a periodic basis. An appropriate objective for disability benefits is, to the extent possible, to make the disabled veteran whole relative to nondisabled veterans.

Principle 5

Benefits and standards for determining benefits should be updated or adapted frequently based on changes in the economic and social impact of disability and impairment, advances in medical knowledge and technology, and the evolving nature of warfare and military service.

Changes in American society and commerce, such as the ubiquitous use of computers over long-distance networks, can change the degree to which certain physical and psychological impairments affect individuals' ability to function. These social and commercial changes should be evaluated regularly in the context of veterans' benefits.

Breakthroughs in medicine, psychology and psychiatry, rehabilitative science, prosthetics, adaptive equipment, and electronics can help disabled veterans attain greater functionality and a higher quality of life. To those ends, disabled veterans should receive access to state-of-the-art health care, rehabilitative services, and adaptive devices.

Research should be conducted to address the unmet needs of disabled veterans and their families. Such research should focus in particular on the conditions of vulnerable and underserved populations, such as those with severe mental illness and traumatic brain injury. Validated research findings must be translated into regulation and policy updates and best practices transmitted to the field.

Principle 6

Benefits should include access to a full range of health care provided at no cost to service-disabled veterans. Priority for care must be based on service connection and degree of disability.

At a minimum, every disabled veteran should receive the health care necessary to assist him or her in living as near normal a life as is possible.

Principle 7

Funding and resources to adequately meet the needs of service-disabled veterans and their families must be fully provided while being aware of the burden on current and future generations.

As noted under Principle 1, the costs of war must be calculated to include benefits for disabled veterans, their dependents, and their survivors well into the future. To maintain the appropriateness of the benefit and the appropriateness of

the level of the benefit, required resources and costs must be systematically projected, responsibly reflected in policy decisions, and provided for in appropriations.

Principle 8

Benefits to our Nation's service-disabled veterans must be delivered in a consistent, fair, equitable, and timely manner.

Benefits should be delivered without stigma, bias, or prejudice against the veteran or their service. Service to country cannot be measured solely by the time spent in the military, but rather should also include the severity of the injuries sustained during that service. Veterans and their families should be able to access benefits in a nonadversarial, customer-driven culture that meets their current needs. Benefits delayed are benefits denied and therefore must meet timely standards for delivery so as not to disenfranchise the veteran. If a veteran is somehow ill served, "lost" in the system, or ignored, it can take years and many additional resources to rectify the situation; this must be avoided at all costs. Therefore, this principle is essential to ensure that veterans are appropriately served.

The Veterans' Disability Benefits Commission leaves these eight guiding principles as a cornerstone for future generations so they may sustain a system that will adapt to the needs of future veterans.

3

Veterans' Past, Present, and Future

This chapter serves as a backdrop to the Commission's analysis of veterans' benefits. The first section of the chapter summarizes milestones in the history of U.S. veterans' benefits, giving the reader a context for those benefits available today. The second and third sections of the chapter outline the demographics of today's veterans and the projected demographics of future veterans for consideration in the development of policies for disabled veterans, their dependents, and their survivors.

I History of Veterans' Benefits

America has a long history of caring for those who have served in defense of the Nation. From the early colonial days to today, veterans and their families have been cared for through various types and iterations of benefits and programs.

American veterans' benefits date back to the colony of Plymouth, which ordered in 1636 that any soldier who became disabled as a consequence of injury while defending the colony would be maintained by the Colony for life.¹ Other colonies followed this lead, which ultimately was continued by the Continental Congress.²

In 1776, the Continental Congress passed a resolution to give a pension to veterans who became disabled during military service. The resolution promised veterans half pay for life in cases of loss of limb or other serious disability.³ Although this resolution was a significant milestone, the Congress lacked the authority and resources to implement the law, and the fulfillment of pension payments was left to the states. The burden of those payments was transferred to the Congress beginning in 1789.⁴

¹ PBS, *Veterans Benefit History*.

² VA, *History in Brief*, 3

³ *Ibid.*, 6

⁴ VA, *History in Brief*, 3

In the early 1800s, all veterans' pensions were administered by the Bureau of Pensions under the Secretary of War. Legislative and administrative changes to veterans' benefits at that time included the extension of benefits to dependents and survivors, the increasing of allowances to match the rising cost of living, and the addition of veterans of militias and state troops to the federal rolls. The era also saw enactment of the Service Pension Law of 1818, which introduced pension payments to the indigent. That law had an immediate impact, increasing the number of pensioners from 2,200 to 17,730.⁵ Controversy surrounded the law, however, with allegations of abuse resulting in a second piece of legislation requiring affirmation of one's income to continue receiving pension payments.

Veterans' pension programs were again affected by legislation in the early 1830s. At that time, the focus was on those veterans' who served during the War for Independence; the legislation adopted a "pure service" principle in which benefits for a life pension were contingent on the amount of time served in the military.⁶

Veterans of the Mexican War (1846-1848) and their dependents received pensions which were limited to death and disability incurred in service, unlike benefits that were in force for veterans of earlier conflicts.⁷

I.1 Civil War

As the nation entered the Civil War, Congress created new benefits and services for veterans and families of the deceased. The General Pension Act of 1862 provided disability payments to Union troops based on rank and degree of disability, and included compensation for illnesses contracted during service.⁸ (Confederate veterans were barred from receiving federal benefits until 1958, when Congress issued a pardon and granted benefits to the few remaining survivors.⁹)

There were an estimated 2.2 million (Union) troops who participated in the Civil War.¹⁰ This influx of troops caused the number of pensioners to rise from about 80,000 veterans before the war to 1.9 million after it ended in 1865.¹¹ With an expenditure of \$117 million in pension benefits, the Federal Government spent

⁵ Veterans Benefits Administration, *Annual Benefits*, 8.

⁶ *Ibid.*

⁷ *Ibid.*

⁸ President's Commission, *Veterans Benefits*, 4.

⁹ VA, *History in Brief*, 4.

¹⁰ President's Commission, *Veterans Benefits*, 62.

¹¹ *Ibid.*, 11.

more on veterans' benefits between 1866 and 1870 than it had during the preceding 75 years.¹²

The period following the Civil War witnessed several legislative efforts take place that solidified the system of veterans' benefits. These included the Arrears Act of 1879 and the Dependent Pension Act of 1890. The former allowed, for the first time, that a claim may be retroactive while the latter broaden pension eligibility to those incapable of manual labor.¹³ Collectively, legislation passed in the 19th century sufficient for its time and that of future needs such that no additional legislation was introduced after the Spanish-American War or the 1899-1901 Philippine Insurrection.¹⁴

I.2 World War I

By the early 20th century, the reconstituted Armed Forces of the United States had grown to more than 4.7 million¹⁵ through a draft instituted by President Woodrow Wilson. These forces were called upon to protect national interests when America entered World War I on April 6, 1917. The doughboys experienced new types of warfare including trench warfare, air warfare, and chemical warfare.

By the time the armistice was signed on November 11, 1918, 204,000 Americans were wounded and 116,708 had died, leaving behind a new generation of widows and orphans.¹⁶ By 1919, when the Versailles Treaty ended the "war to end all wars," disabled service members were discharged at a rate of 23,000 per month, stimulating institutional changes and shifts in responsibility in the administration of veterans' benefits through the early 1920s.

In 1921, President Warren G. Harding created a commission to reform the World War I veterans' benefits system. The commission recommended the formation of a single administrative agency to streamline the administration of veterans' benefits.

Consequently, the Veterans Bureau Act of 1921 consolidated the undertakings of the Federal Board for Vocational Education, the Bureau of War Risk Insurance, and the U.S. Public Health Service component that cared for World War I veterans. However, the Veterans Bureau quickly became an unwieldy organization fraught with waste, fraud, and abuse. Congress responded by

¹² VA, *Veterans Benefits Administration*, 9.

¹³ *Ibid* 10-11

¹⁴ *Ibid* 12

¹⁵ President's Commission, *Veterans Benefits*, 62.

¹⁶ VA, *History in Brief*, 7.

enacting the World War Veterans Act of 1924, which was intended to remedy the blurring and overlap of previously passed laws and to liberalize accrued benefits to disabled World War I service members.¹⁷

Although rating schedules had existed since 1917, the first *official* schedule for rating veterans was promulgated in 1921.¹⁸ The schedule rated specific injuries and diseases according to their estimated impact on "average impairments of earning capacity resulting from such injuries in civil occupations."¹⁹ In 1924, the law was revised by adding the phrase "similar to the occupation of the injured man at the time of enlistment" World War Veterans' Act of 1924, Pub. L. No. 242, 1924. In response, a new schedule of disability ratings was implemented in 1926²⁰ that considered occupational factors in evaluating the impact of a given impairment—an innovation for the time.²¹ For instance, a lawyer and a carpenter who each lost a leg received different amounts of compensation for their injuries. The lawyer was viewed as less affected because his profession was mostly sedentary, so he received less compensation than the carpenter, who needed mobility to work. Despite the merits of this approach to compensation in theory, it soon became viewed as overly subjective and complex in practice. Another problem was the rating of young veterans who had never been employed before serving.²² Consequently, VA issued a new schedule, the VA Schedule for Rating Disabilities (VASRD), in 1933 that returned to the average impairments in civil occupations philosophy of the 1921 rating schedule.²³ The revision also established policies on reasonable doubt, combined ratings, and other factors still in effect in 2007.²⁴ A second edition of the VASRD was also published in 1933.

In 1930, Congress authorized the consolidation of the Veterans Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers into a single independent agency: the Veterans Administration (VA).²⁵ The consolidated agency administered benefits to 4.7 million veterans and brought together medical and domiciliary services, World War I compensation and allowances, government life insurance, adjusted service certificates, emergency officers' retirement pay, Army and Navy pensions, and civilian employee retirement.²⁶ By 1933, VA had 54 regional offices that adjudicated claims,

¹⁷ VA, *Veterans Benefits Administration*, 19.

¹⁸ Veterans Bureau, *Disability Rating Table*.

¹⁹ Dillingham, *Federal Aid to Veterans*, 39.

²⁰ President's Commission, *Disability Rating Schedule*, 47.

²¹ McBrine, *Rating Schedule*.

²² Dillingham, *Federal Aid to Veterans*, 48.

²³ McBrine, *Rating Schedule*.

²⁴ *Ibid.*

²⁵ VA, *Veterans Benefits Administration*, 19.

²⁶ *Ibid.*, 25.

provided medical and dental treatment, collected insurance premiums, and made loans. The Board of Veterans Appeals (BVA) was established the same year.

In light of the Great Depression, a newly elected President Franklin D. Roosevelt was concerned with controlling the Federal budget and promoting economic reform through his New Deal plan. In that context, he rescinded all veterans' benefits dating back to the Spanish-American War by signing the Economy Act of 1933.²⁷ Under an Executive authority, President Roosevelt then issued 12 regulations that effectively cut veterans' benefits by 88 percent. However, when this authority expired in 1935, Congress reinstated many of those benefits.²⁸

In 1936, overriding a veto by President Roosevelt, Congress authorized early payment of the World War I insurance bonuses. Some 3.5 million World War I veterans collected their lump sum, resulting in a \$2.5 million disbursement from the Federal Government.²⁹ Also significant at this time was the passage of the Social Security Act of 1935, which relied on employer and employee contributions to care for the elderly and disabled, including veterans.³⁰ Active duty service members did not have their military pay withheld for Social Security contributions until 1956.

During the 1930s, many veterans sought medical care, especially during a tuberculosis epidemic. The number of VA hospitals increased from 64 to 91, and bed capacity increased from 33,669 to 61,849. VA research made its first significant contribution to medicine when it broke ground in the treatment of tuberculosis, which plagued the population of VA patients; by the mid-1930s, the disease affected only 13 percent of that population.³¹ Neuropsychiatric patients then accounted for more than half of VA's patient population.³²

I.3 World War II

The failures of the Versailles Treaty, economic hardships, and the impotence of the League of Nations set the stage for World War II. Although the United States attempted to remain neutral, Congress enacted the Selective Training and Service Act of 1940, America's first peacetime draft, which guaranteed reemployment to anyone who left a job for military service.³³ The draft called

²⁷ Ibid., 27.

²⁸ Ibid.

²⁹ Ibid., 22.

³⁰ Nelson, *About the Great Depression*.

³¹ VA, *History in Brief*, 12.

³² Ibid., 12-13.

³³ Ibid.

800,000 men to service, overriding the previously set legal limit of 375,000³⁴ and far outstripping the size of the 185,000-man standing Army that the country had previously maintained exclusively on U.S. soil. Isolationism remained the widespread political sentiment, and President Roosevelt refused to enter another European conflict until the Japanese attacked Pearl Harbor on December 7, 1941. Four days later, Hitler declared war against the United States.

To fight the war, the United States mobilized more than 16.5 million Americans,³⁵ the largest mobilization in U.S. history, including many more women and minorities than ever before. In total, 671,876 American troops were wounded and 405,399 died, leaving many dependents in need.³⁶ For every three Americans killed in action, two died from other causes.³⁷ Advances in armaments, the conditions in prisoner of war (POW) camps, and experimentation with atomic radiation gave World War II veterans' health challenges not experienced by previous generations. In particular, psychiatric casualties increased by 300 percent from World War I to World War II and accounted for 23 percent of all evacuees. The traumatic aftereffects of combat were widely rejected as the cause of these psychiatric casualties.

The VA Schedule for Rating Disabilities (VASRD) underwent its last major revision in 1945 to account for World War II veterans' organ-system injuries and illnesses. In a significant change, the revised VASRD allowed VA to reevaluate a veteran and change his disability rating—and consequently the amount of compensation he received—if the veteran had recovered from his original service-connected disability. Previously, a veteran's original disability rating could not be changed.³⁸ The revised 1945 version of the VASRD forms the foundation of the VA Schedule for Rating Disabilities in effect today.

Between 1945 and 1962, testing programs for nuclear weapons exposed thousands of participants to ionizing radiation,³⁹ yet veterans did not receive assistance for health problems associated with ionizing radiation until 1981. That year, Congress authorized medical and nursing home care for such health problems, and in 1988 it authorized disability compensation for diseases associated with radiation.⁴⁰

³⁴ Sulzberger, *American Heritage Picture History*, 130.

³⁵ President's Commission, *Veterans Benefits*, 62

³⁶ VA, *Veterans Benefits Administration*, 30.

³⁷ Summers, *Vietnam War Almanac*, 111.

³⁸ Institute of Medicine, *21st Century System*, 86.

³⁹ VA, *History in Brief*, 21

⁴⁰ *Ibid.*

While President Roosevelt tasked two different committees to explore options for the 12 million service members about to demobilize, The American Legion drafted the GI bill of rights, a plan that included hospitalization, employment, home and business loans, mustering-out pay, and education. Within 6 months, Congress passed the Servicemen's Readjustment Act of 1944, more commonly known as the GI Bill.⁴¹ Five years after the end of World War II, four out of every five veterans received benefits under one or more of the three major GI Bill programs for education and training, home loans, and unemployment compensation.⁴² By 1955, veterans who used their GI Bill benefits had higher income levels than nonveterans of similar age, were more likely to be in professional and skilled occupations, and were better educated. Three out of five married veterans owned their own homes.⁴³ The GI Bill paved the way for World War II veterans to become known as the "Greatest Generation," given their considerable contributions to the American economy and social structure.

In response to explosive growth of the veterans' population—from 4.3 million in 1942 to more than 18.2 million in 1947—VA reorganized to meet occupational and educational needs. In 1946, VA added the Vocational Rehabilitation and Education division, which had 13 branch offices and 69 regional offices.

I.4 The Cold War

The end of World War II fostered the standoff that became the Cold War, as the United States and the Soviet Union warily monitored each other's every move. In 1947, the National Security Act created the Department of Defense (DoD) to oversee the three service branches, gave oversight authority to the Joint Chiefs of Staff, established the National Security Council to advise the President, and created the Central Intelligence Agency.⁴⁴ The Truman Doctrine and the Marshall Plan to contain Communism became defining American policy for the next 30 years⁴⁵ and led America to maintain a strong military presence around the world. In 1950, when the North Koreans crossed the 38th parallel, the United States responded with force. The selective service draft was reinstated in 1951.

I.5 The Korean War

Almost 1.5 million World War II veterans returned to duty to become part of the 6.8 million troops mobilized from 1950 to 1953 to stop Communist expansion in Korea.⁴⁶ These troops not only faced combat wounds, but also injuries from

⁴¹ VA, *Veterans Benefits Administration*, 30.

⁴² President's Commission, *Veterans Benefits*, 254.

⁴³ *Ibid.*, 254, 266-267.

⁴⁴ Ambrose, *Rise to Globalism*, 140.

⁴⁵ *Ibid.*, 132.

⁴⁶ President's Commission, *Veterans Benefits*, 62.

extreme cold and frost. With new strides in medicine and the advent of the MASH unit, lives were saved at a greater rate during the Korean War than during World War II.⁴⁷ Notwithstanding, 54,256 American service members died from injuries and diseases in Korea⁴⁸ and 103,284 were wounded.⁴⁹

In a departure from previous wars, the military took a more realistic approach to psychiatric casualties of the Korean War. The recognition that service members suffering from combat stress needed immediate treatment in the field decreased the evacuation rate for psychiatric reasons from 23 percent in World War II to 6 percent.⁵⁰

As Korean veterans readjusted to civilian life, those with disabilities immediately benefited from the programs already established under the Vocational Rehabilitation Act of 1950. Eventually, 77,000 veterans availed themselves of the programs created by that act.⁵¹ In 1952, 2.5 million veterans were receiving outpatient care, and VA was disbursing \$125 million in compensation and pensions.⁵² The "Korean GI Bill," enacted in 1952, provided benefits similar to those granted to World War II veterans, but with limitations and restrictions designed to mitigate administrative problems and abuses that had riddled implementation of the original GI Bill.⁵³ These problems contributed to the decision to reorganize VA in 1953. That reorganization created the Department of Medicine and Surgery, the Department of Insurance, and the Department of Veterans Benefits.⁵⁴

After the fighting in Korea ended, the President's Commission on Veterans' Pensions chaired by General Omar Bradley deliberated on the status of veterans' benefits and expressed guidelines for the future.⁵⁵ The Bradley Commission found in 1956 that the "present structure of veterans' programs is not a 'system,' but an accretion of laws based largely on precedents built up over 150 years of piecemeal development."⁵⁶ The Bradley Commission believed that most programs were sound, but that some were in

urgent need of revision and modernization to bring them in line with the basic changes which [sic] have occurred and are still occurring in our society. There is, at present, no clear national philosophy of

⁴⁷ Summers, *Vietnam War Almanac*, 111.

⁴⁸ *Ibid.*, 112.

⁴⁹ Office of Public Affairs, *America's Wars*.

⁵⁰ Goodwin, "Etiology," 2.

⁵¹ VA, *Veterans Benefits Administration*, 33.

⁵² *Ibid.*, 39.

⁵³ *Ibid.*, 33.

⁵⁴ *Ibid.*, 41.

⁵⁵ President's Commission, *Veterans Benefits*, 9-13.

⁵⁶ *Ibid.*, 9.

veterans' benefits. This Commission has endeavored to develop a philosophy and guiding principles, on the basis of which our national obligation to veterans can be discharged generously.⁵⁷

Consequently, the Veterans Benefits Act of 1958 revised, codified, and enacted as title 38 of the United States Code all laws relating to VA.⁵⁸ The Bradley Commission accurately predicted the return of the draft that would bring the population of veterans to approximately 25 million at the close of the century.

I.6 Vietnam War

More than 8.7 million men and women served in the military during the Vietnam War, 3.4 million of them specifically in Southeast Asia.⁵⁹ By 1975, when the last Americans in Vietnam were evacuated, 57,690 troops had lost their lives and 303,704 were wounded.⁶⁰

Only 12 in 1,000 troops needed to be evacuated from Vietnam for psychiatric casualties, an all-time low for the U.S. military⁶¹ attributed to the advances in military psychology made during the Korean War.⁶² Despite the low proportion of psychiatric casualties on the battlefield, many factors specific to the Vietnam War and American culture at the time left many veterans with psychiatric problems long after the war ended. In addition, some veterans gradually developed diseases correlated to exposure to the harmful contaminant dioxin in Agent Orange, a herbicide that U.S. troops sprayed to defoliate jungles.

Unique characteristics of the Vietnam War accounted for the level of emotional stress that those veterans experienced. Unlike previous wars, Vietnam combatants rotated in and out of country alone, and not as a unit. Enemy troops engaged in guerrilla warfare in dense jungles and were not as easily identifiable as World War II enemy troops. Civilians could be just as dangerous as soldiers. There were no battle lines and no front. Booby traps were common. Land was secured, but not held. The drug culture and racial issues prevalent in America at the time seeped into the military, affecting unit cohesion. These factors combined to impose high levels of psychological stress on many U.S. troops.⁶³

Above and beyond the challenges in the war zone, the controversy in the United States over the Vietnam War had emotional repercussions for the war's veterans.

⁵⁷ Ibid., 10.

⁵⁸ VA, *Veterans Benefits Administration*, 41.

⁵⁹ VA, *Fact Sheet: America's Wars*.

⁶⁰ Summers, *Vietnam War Almanac*, 111.

⁶¹ Goodwin, "Etiology," 3.

⁶² Ibid.

⁶³ Ibid., 3-7.

The lack of concrete strategic objectives, ineffectiveness of U.S. operational concepts for defeating the enemy, death toll among both American service members and Vietnamese civilians, and other factors led many U.S. citizens and veterans to protest the war. Graphic images from the battlefield were broadcast on television into American homes for the first time in U.S. history, which had an acute emotional impact on the civilian population. As service members became increasingly aware of the antiwar movement in the United States, it dampened their morale.⁶⁴ Antiwar activists vented their discontent on veterans as they returned home from the war, creating an unwelcoming and even hostile environment on college campuses, in workplaces, in churches, and even at VSO posts. These factors plus a depressed American economy contributed to many veterans' disillusionment and poor readjustment to civilian life.^{65,66} Emotional problems plagued an estimated 800,000 Vietnam veterans by 1985.⁶⁷ Although those veterans had not manifested the same rate of neuropsychiatric disorders during active duty as had World War II or Korean War veterans, Vietnam veterans were more likely to suffer psychiatric symptoms years after returning home.

I.7 Vietnam Era Benefits

In 1965, Congress created the largest-ever national insurance program with the passage of Servicemen's Group Life Insurance (SGLI), and the next year, Congress passed the Vietnam GI Bill to restore educational benefits.⁶⁸

VA attempted to engage Vietnam veterans in benefits programs by placing VA representatives in Long Binh in 1967 and by installing toll-free phone lines to regional VA offices in each state.⁶⁹ Congress attempted to increase veterans' participation in education programs through amendments to the GI Bill in 1970, 1972, and 1974, and through the 1977 Vietnam Era Veterans' Educational Assistance Act (VEAP). In 1979, VA opened its first Vet Center tailored to the needs of Vietnam-era veterans. Despite these efforts, some Vietnam veterans avoided government assistance and succumbed to illness, substance abuse, homelessness, incarceration, or suicide.

Vietnam veterans and their families brought the Agent Orange product liability litigation against major manufacturers of the herbicide in 1978.⁷⁰ The resolution of the lawsuit in 1984 for \$180 million led to the creation of the Agent Orange

⁶⁴ Ibid.

⁶⁵ Ibid., 7.

⁶⁶ Brende and Parson, *Vietnam Veterans*, ix.

⁶⁷ Ibid., 21.

⁶⁸ VA, *History in Brief*, 18.

⁶⁹ Ibid., 19.

⁷⁰ VA, *Agent Orange—Herbicide Exposure*.

Settlement Fund, which was distributed to class members through two programs: the Payment Program, which distributed funds to totally disabled Vietnam veterans or their survivors, and the Agent Orange Class Assistance Program (AOCAP), which funded 72 programs that assisted nearly 200,000 veterans and their families in every state for 6 years.^{71,72} AOCAP gave grants to existing small local agencies, nonprofits, VSOs, and related organizations that provided grassroots support services, outreach, and treatment. Case managers tracked the progress of many veterans who participated in AOCAP-funded programs. The success of these community-based programs with case managers influenced VA to change the way it delivered treatment and services to veterans.

VA responded to health concerns related to Agent Orange by providing medical care beginning in 1978. Eligibility for medical treatment for illnesses related to Agent Orange was expanded in 1981. In the early 1990s, VA began granting compensation for cases of chloracne, soft-tissue sarcoma, and non-Hodgkin's lymphoma thought to be connected to exposure to Agent Orange. The Agent Orange Act of 1991 provided presumptive service connection for diseases caused by exposure to the herbicide. VA began granting compensation in 1993 for other cancers presumed to be connected to wartime exposure to Agent Orange.⁷³ A study that found a correlation between Agent Orange and the birth defect that causes spina bifida led VA in 1997 to provide benefits to more than 940 children who had the disease and were the offspring of Vietnam veterans.⁷⁴

I.8 Post-Vietnam Era

In 1973, the draft system that had been in place for over 30 years was replaced by an all-volunteer force. At the same time, World War II veterans began turning 65 years of age and looked to VA for pensions. Consequently, the number of pensioners increased from 89,526 in 1960 to 691,045 in 1978.⁷⁵

To facilitate recruiting, Congress passed the Veterans' Educational Assistance Act of 1984, otherwise known as the Montgomery GI Bill (MGIB).⁷⁶ The first peacetime GI Bill, MGIB successfully attracted volunteers to the military and helped them attain their long-term educational goals. The New GI Bill Continuation Act of 1987 made the MGIB permanent. By 1990, approximately 900,000 service members had participated in MGIB programs,⁷⁷ representing a

⁷¹ Ibid.

⁷² Rhodes, Leaveck, and Hudson, *Legacy of Vietnam Veterans*, xv–xvi.

⁷³ VA, *History in Brief*, 20.

⁷⁴ Ibid.

⁷⁵ Ibid., 23.

⁷⁶ VA, *Federal Benefits for Veterans and Dependents*, 29–33.

⁷⁷ VA, *Veterans Benefits Administration*, 59.

72 percent participation rate. In contrast, only 20 percent of eligible individuals had participated in the Vietnam GI Bill by 1978.⁷⁸

In 1986, Congress limited access to free medical care from VA. Only individuals who were considered indigent or disabled by VA or were part of certain special groups (e.g., former prisoners of war) could receive health care from VA without payment. All others had to pay for part of their treatment.⁷⁹ In 1990, Congress no longer allowed previously low-income wartime veterans over the age of 65 to automatically be classified as disabled.

President Ronald Reagan elevated the Veterans Administration to a Cabinet-level department in 1988. The new Department of Veterans Affairs contained the Veterans Benefits Administration (VBA), the Veterans Health Administration (VHA), and the National Cemetery System (later to also become an administration). At the same time, Congress created the Court of Veterans Appeals as a component of the Judicial Review Act, giving veterans the ability to appeal decisions by the Board of Veterans Appeals (BVA) to an independent court.⁸⁰

In response to a report by the General Accounting Office (GAO), VBA began an update in 1989 of each of the 14 body systems sections of the VASRD, but only completed 11 of the sections, and never fully completed a comprehensive review as GAO had initially advised and VA had agreed.⁸¹

Before 1990, veterans of war who were older than 65 years and considered by VA to have low incomes automatically became classified as disabled—even if they lacked a true disability—and received disability pensions. That policy changed with the passage of the Omnibus Budget Reconciliation Act of 1990. The new law required that to be determined totally disabled, a veteran of any age had to be unemployable as a result of a disability.⁸²

I.9 The Persian Gulf War

Some 700,000 American troops were deployed to the Persian Gulf in response to the Iraqi invasion of Kuwait in 1990.⁸³ U.S. forces and their partners from other countries quickly accomplished their mission. Within months after

⁷⁸ *Ibid.*, 58-59.

⁷⁹ VA, *History in Brief*, 23.

⁸⁰ VA, *Veterans Benefits Administration*, 66.

⁸¹ Institute of Medicine, *21st Century System*, 92.

⁸² VA, *History in Brief*, 25.

⁸³ Institute of Medicine, *Gulf War Veterans*, 12.

demobilization, some individuals who served in the Persian Gulf War began reporting symptoms that were difficult to relate and diagnose. In response to the concern that environmental exposures to substances in the Persian Gulf region caused these symptoms, Congress legislated that VA should obtain independent evaluations of the scientific evidence of associations between symptoms and exposures to various chemical, biological, and physical substances connected to military service in the Persian Gulf region during the war.⁸⁴ These evaluations are ongoing; none so far has identified a single cause for what is commonly termed "Gulf War Illnesses." Veterans who suffered from Gulf War Illnesses were the first generation of veterans for whom an undiagnosed illness was deemed to be service connected.

I.10 Reforms to Delivery of VA Health Care and Benefits

VHA underwent a sweeping restructuring beginning in 1994.⁸⁵ This restructuring set the stage for a significant change in veterans' access to health care marked by the passage of the Veterans' Healthcare Eligibility Reform Act of 1996. Before the law was passed, the only individuals allowed free access to the VA health care system were those deemed disabled or indigent by VA standards or belonging to a special group (e.g., former prisoners of war). After the law's implementation, VA had the authority to use a means test and enhanced third party billing. The law's passage also enabled VA to eliminate the distinction between hospitalization and outpatient care and to provide prevention services and primary care.⁸⁶ To help VA estimate the costs it would incur under the new policy, the law placed each veteran in one of seven priority groups based on an array of factors including level of disability, level of income, and POW status.⁸⁷ In addition, VA reorganized its medical centers into 22 Veterans Integrated Service Networks (VISN), each of which determined how best to serve the veterans in its geographic area.⁸⁸ (Later, VISN 14 and 15 were combined into VISN 23 for a total of 21 networks.) The VISNs can electronically track patient records throughout the health-care system.

Health care eligibility reform and the restructuring of the VA health care system resulted in improved access to primary care, shifted the delivery of care from predominantly inpatient to predominantly outpatient, and allowed for greater accountability and performance measurement. As a consequence of the restructuring, the number of unique patients treated in the VA health care system

⁸⁴ Institute of Medicine, *Gulf War and Health*.

⁸⁵ VA, *Prescription for Change*, 5.

⁸⁶ VA, Employee Handbook, 0-1-0-2

⁸⁷ VA, *Eligibility Reform*.

⁸⁸ Government Accountability Office, *VA Health Care*.

rose from 3.0 million in FY 1998 (before enrollment) to 3.4 million in FY 2000 (one year after enrollment began) to 4.9 million in FY 2006.⁸⁹

In 2001, VHA undertook the Capital Asset Realignment for Enhanced Services (CARES) study, which recommended that VA close some facilities while expanding other points of care. By 2004, new construction projects were requested, community-based outpatient clinics (CBOCs) expanded to over 850 sites, rural access issues were being addressed, and sharing initiatives between VA and DoD were being created.⁹⁰

To improve VA services to service members who were transitioning back into civilian life, VA and DoD jointly created the Benefits Delivery at Discharge (BDD) program in 2000 so service members could file claims with VA while still on active duty. Some 40,600 transitioning service members filed original compensation claims through the BDD program in fiscal year 2006.⁹¹

Vet Center eligibility was extended in 1991 to veterans from conflicts in Lebanon, Grenada, Panama, and Somalia; in 1996, that eligibility was expanded further to include veterans of World War II and Korea.

I.11 The Global War on Terrorism

On September 11, 2001, Americans watched as the twin towers of the World Trade Center collapsed, a section of the Pentagon burned, and smoke rose from a field in Pennsylvania after the hijacking of four jetliners by members of Al Qaeda. By the end of that day, almost 3,000 people had died in the deadliest attack on American soil since Pearl Harbor. In response, President George W. Bush declared a Global War on Terrorism. Troops were sent to Afghanistan for Operation Enduring Freedom (OEF), and later in 2003, to Iraq for Operation Iraqi Freedom (OIF).

As the war continued, some 1.3 million men and women were on active duty in 2006, while another 1.1 million served in the National Guard and the Reserves, often on double and triple deployments.⁹² Injuries to deployed OEF and OIF service members include amputations, traumatic brain injury, blindness, burns, and multiorgan system damage. Yet a record 85 percent of the injured have

⁸⁹ Kendall, E-mail message.

⁹⁰ VA, *CARES Decision*, 4–5.

⁹¹ VA, *Annual Performance and Accountability Report*.

⁹² DoD, *DefenseLink*, DoD 101.

survived as of August 2007, thanks to improvements to body armor and coagulants and the modern medical evacuation system.⁹³

DoD and the service branches have created specialized programs for the severely injured, and VA has retooled its approach to rehabilitation for polytrauma. Transition assistance programs are being offered, outreach is being conducted at multiple levels, and the Benefits Delivery at Discharge program is available at 140 installations. Traumatic Servicemembers' Group Life Insurance (TSGLI) became effective in December 2005 to provide financial assistance to the severely injured. This traumatic injury protection rider pays a lump sum to any service member who sustains a severe injury. TSGLI pays between \$25,000 and \$100,000 depending on the severity of the injury.

II Demographics of Today's Veteran Population

About 23.5 million veterans live in the United States and Puerto Rico in 2007, accounting for about 8 percent of the U.S. population.^{94,95} The number of veterans has been decreasing for more than a decade. From 2000 to 2004, the size of the veterans' population shrunk by an average of 437,000 people a year, or 1,200 a day.⁹⁶

Table 3.1 illustrates the total number of living veterans by unique periods of wartime service and the approximate percentage of each population receiving disability benefits at the end of fiscal year (FY) 2006. There are also many veterans, especially retirees, who have served during peacetime, during both peacetime and wartime, or during multiple wars (Table 3.2). Vietnam veterans were the largest group in the veteran population at the end of FY 2006 and the largest group receiving service-connected disability benefits at that time (Table 3.1). Note that the percentage of each group receiving benefits relates only to the number of living veterans, not to the percentage of all veterans who served during those periods. For example, over 16 million individuals served during World War II, but only 3.5 million of them remain alive.

Today's veterans are an average of 58 years old, and the majority of veterans are between 45 and 64 years old.⁹⁷ There are about 9.2 million veterans aged

⁹³ DoD, *DefenseLink, Department of Defense Casualty Reports*.

⁹⁴ Office of the Actuary, *Veterans by State, Age Group, Period, Gender*.

⁹⁵ Population Projections Branch, *Interim Projections by Age, Sex, Race, and Hispanic Origin*.

⁹⁶ Office of the Actuary, *Veterans by State, Age Group, Period, Gender*.

⁹⁷ VA, *2001 National Survey of Veterans*, 3–4.

65 or older, representing 38 percent of the veteran population.⁹⁸ By contrast, the median age of the U.S. population is 35 years.⁹⁹

Table 3.1 Veterans Receiving Service-Connected Disability Benefits at End of FY 2006 by Period of Wartime Service

UNIQUE PERIOD OF WARTIME SERVICE	NUMBER OF LIVING VETERANS ^a	VETERANS RECEIVING SERVICE-CONNECTED DISABILITY BENEFITS	
		No. ^b	Percentage (%)
World War II	3,525,769	328,042	9.3
Korean War	3,256,925	159,804	4.9
Vietnam War	8,054,993	947,598	11.7
Gulf War	4,377,845	694,813	15.9
Global War on Terror	588,923 ^c	Not available	Not available

^a Veteran Data and Information, VA. *Table 2L: Veterans by State, Period, Age Group, Gender, 2000-2033*. Washington, DC: VA, 1995. www1.va.gov/vetdata/docs/2l.xls.

^b Hessling, E-mail message.

^c This figure is for Nov. 2006. Office of Public and Intergovernmental Affairs, VA. *Fact Sheet: America's Wars*. Washington, DC: VA. <http://www1.va.gov/opa/fact/amwars.asp>.

Table 3.2 Veterans Receiving Service-Connected Disability Benefits, End of FY 2006

PERIOD OF SERVICE	NUMBER OF LIVING VETERANS ^a	VETERANS RECEIVING SERVICE-CONNECTED DISABILITY BENEFITS	
		No. ^b	Percentage (%)
Wartime	18,155,573	2,130,259	11.7
Peacetime	6,231,463	595,565	9.6
All periods	24,387,036	2,725,824	11.2

^a Veteran Data and Information, VA. *Table 2L: Veterans by State, Period, Age Group, Gender, 2000-2033*. Washington, DC: VA, 1995. www1.va.gov/vetdata/docs/2l.xls.

^b Marshall, E-mail message.

II.1 Service-Connected Disability

More than 2.7 million veterans had service-connected disabilities at the end of FY 2006, a 14 percent increase over the number at the end of FY 2002.¹⁰⁰ The

⁹⁸ VA, *Fact Sheet: Research in VA Geriatrics*.

⁹⁹ Census Bureau, *Census 2000 Summary*.

¹⁰⁰ Marshall, E-mail message.

three most prevalent service-connected disabilities among veterans receiving compensation at the end of FY 2006 were musculoskeletal disorders, auditory disorders, and skin disorders.¹⁰¹

Compensation for disability is determined by the number of conditions considered to be connected to military service, the degree to which each condition is disabling, and the overall degree of disability caused by the conditions combined. Chapter 4 contains an in-depth discussion of the disability rating system.

Table 3.3 illustrates the number of veterans with service-connected disabilities who received VA compensation and the average amounts of compensation received per person in FY 2006, the most recent year for which data are available. As of 2006, the average cost of compensation was \$9,381 per disabled veteran.¹⁰² 28.4 percent of all service-disabled veterans have combined ratings of 10 percent. 56.7 percent of all service-disabled veterans have combined ratings of 30 percent or less.

Veterans have, on average, three different disabilities for which they are rated. A 10 percent rating is the most common individual rating; 40 percent of all ratings are at the 10 percent level. Some 89 percent of all individual ratings are between 0 percent and 30 percent.¹⁰³

¹⁰¹ Ibid.

¹⁰² Ibid.

¹⁰³ Veterans Benefits Administration, *Annual Benefits Report*, 27.

Table 3.3 Estimated Amount of Service-Connected Disability Compensation Paid and Number of Veterans Receiving Compensation, End of FY 2006

COMBINED DEGREE OF DISABILITY (%)	NUMBER OF VETERANS	ESTIMATED TOTAL ANNUAL AMOUNT PAID (\$)	ESTIMATED AVERAGE ANNUAL AMOUNT PAID PER VETERAN (\$)
0	14,309	\$12,749,510	\$891
10	779,789	\$1,054,734,550	\$1,353
20	421,709	\$1,113,945,680	\$2,642
30	335,358	\$1,509,571,822	\$4,501
40	260,165	\$1,695,282,651	\$6,516
50	161,774	\$1,480,760,925	\$9,153
60	184,499	\$2,804,358,638	\$15,200
70	165,468	\$3,694,285,023	\$22,326
80	113,549	\$2,818,009,618	\$24,818
90	60,623	\$1,642,610,621	\$27,096
100	238,966	\$7,843,014,446	\$32,821
Total	2,736,209	\$25,669,323,485	\$9,381

^a "Combined" means the percentage captures the total degree of disability from one or more service-connected injuries or illnesses.

Source: Hessling, E-mail message.

II.2 Survivors

More than 326,000 spouses, children, and parents of deceased service members who died on active duty or of service-connected conditions were receiving more than \$4.3 billion in annual service-connected death benefits at the end of FY 2006.¹⁰⁴ On average, each survivor received \$13,187 in annual compensation at that time.¹⁰⁵ Some 11,700 of the survivors were the children of the deceased; members of that group on average received \$6,357 in annual compensation. Most of the beneficiaries—over 41 percent—were survivors of Vietnam War veterans, and nearly 32 percent were survivors of World War II veterans.¹⁰⁶

II.3 Racial Composition of the Veteran Population

Table 3.4 illustrates the racial composition of the veteran population according to the 2000 U.S. Census.

¹⁰⁴ Hessling, E-mail message

¹⁰⁵ Ibid.

¹⁰⁶ Ibid.

Native American veterans (including Alaskans and Hawaiians) have the highest rate of military service per capita of any ethnic group, yet it can be challenging for those veterans to access the health care and other benefits they need because of the remote locations of many of the reservations and rural communities where they live.¹⁰⁷

Table 3.4 Numbers of Veterans by Race and Hispanic Origin^a, 2000

RACE	NUMBER OF VETERANS	PERCENT OF TOTAL VETERAN POPULATION (%)
Caucasian alone	22,573,027	85.5
Black or African-American alone	2,571,981	9.7
Hispanic or Latino (of any race)	1,139,179	4.3
Asian alone	284,297	1.1
American and Alaskan Native alone	195,871	0.7
Native Hawaiian and other Pacific Islander alone	28,592	0.1
Other race alone	367,867	1.4
Multiracial	382,067	1.4

NOTE: Respondents were given the opportunity to choose more than one racial category. The groups designated "alone" indicate that the veteran chose to identify with only one racial group.

^a "Hispanic" was not considered a race by the creators of this table.

SOURCE: Richardson, Christy and Judith Waldrop. *Veterans: 2000: Census 2000 Brief*. Washington, DC: U.S. Census Bureau, 2003, 10. <http://www.census.gov/prod/2003pubs/c2kbr-22.pdf>; Center for Minority Veterans, *Veterans by Race: Census 2000*. Washington, DC: VA, 2006. <http://www1.va.gov/centerforminorityveterans/page.cfm?pg=5>.

II.4 Women

Today's 1.7 million female veterans¹⁰⁸ make up 6 percent of the total veteran population, and 15 percent of the current armed forces are women. The 2001 National Survey of Veterans found female veterans to be younger than their male counterparts, more likely to have college degrees, and more likely to classify themselves as Black.¹⁰⁹ African-American women are the largest group of

¹⁰⁷ Huff, "Crossing the Cultural Divide," 22–24.

¹⁰⁸ VA, *VetPop 2004*.

¹⁰⁹ VA, *2001 National Survey of Veterans*.

minority women serving in the military today, comprising 30.8 percent of female service members.¹¹⁰ The most common conditions for which VA treated female veterans in 2004 were hypertension, depression, and hyperlipidemia.¹¹¹

II.5 Veterans' Families

Family issues are of great importance to today's veterans—almost 75 percent of them are married¹¹²—yet VA does not have the same statutory authority as DoD to provide services to the families of the severely disabled. The Civilian Health and Medical Program of VA (CHAMPVA) is authorized to provide health care to dependents of veterans who are totally and permanently disabled or who were so at the time of death, and to the surviving spouses or children of service members who died in the line of duty, not due to misconduct, and who are not eligible for DoD's Tricare health care program.¹¹³ CHAMPVA had 263,700 beneficiaries enrolled in 2005.¹¹⁴

The Vet Centers are providing some family counseling services, especially to bereft families who have recently experienced an active duty death; however, this authority is limited. Spouses, parents, grandparents, and siblings have become a growing presence at VA facilities as they help care for severely injured service members.

The changing composition of the American military has significant implications. VA must be able to care for the younger veterans of the Global War on Terror and their families while maintaining the infrastructure that fulfills the need for long-term care of the veterans of wars and conflicts dating back to World War II. VA and DoD also need to care for the growing numbers of women, minorities, and married veterans. It is with an understanding of these factors that the Commission contemplates how to shape benefits for future generations of disabled American veterans.

III Demographics of Tomorrow's Veteran Population

In crafting recommendations that will affect future generations of veterans, the Commission studied demographic projections for the United States overall and

¹¹⁰ Evans, *Out of the Shadows*, 26.

¹¹¹ Center for Women Veterans, *National Summit*, 43.

¹¹² VA, *2001 National Survey of Veterans*, 3–4.

¹¹³ VA, *CHAMPVA*.

¹¹⁴ Data on the Civilian Health and Medical Program of VA was given to the Commission by the Health Administration Center in Denver, CO, in 2006.

the veteran population specifically. An estimated 1.1 million new veterans are projected to enter the population between 2006 and 2030 (Table 3.5). DoD is expected to maintain troop strength at about 2.4 million active-duty personnel, National Guardsmen, and reservists;¹¹⁵ thus, projections of the numbers of new veterans through 2030 should remain accurate, absent a major or long-term conflict. In other trends, the population of veterans is expected to decline sharply during the next several decades (Table 3.5). Increases in the proportion of women veterans and in ethnic and racial diversity among veterans are also anticipated.

III.1 Aging and Shrinking of the Veteran Population

The population of veterans is projected to shrink by nearly 37 percent between 2006 and 2030 because the death rate—primarily deaths of World War II veterans—is projected to exceed the rate of separations from the military. The greatest percentage declines will occur in northeastern states, and the smallest, in southern and western states.¹¹⁶ Some of the most populous states, such as California, New York, and New Jersey, will lose the greatest percentages of veterans.

The majority of veterans from the Vietnam era will be 65 or older by 2011. Although the population of veterans over age 65 is decreasing, the rate at which those veterans use VA benefits is increasing, and this trend is expected to continue.¹¹⁷ The number of veterans aged 85 years or older presently exceeds 1 million and is projected to rise through 2010, then to begin declining by 2020 and to number about 1.4 million in 2033.¹¹⁸

According to VA, “As the veteran population ages, the demand for geriatric and all forms of long-term care should increase significantly relative to acute care. In particular, nursing home care policies, programs, and services will require continual monitoring and assessment.”¹¹⁹

¹¹⁵ Defenselink, DoD 101

¹¹⁶ VA, *VetPop April 2001*.

¹¹⁷ Federal Interagency Forum, *Older Americans Update 2006*, 51.

¹¹⁸ VA, *Fact Sheet: Research in VA Geriatrics*.

¹¹⁹ Klein and Stockford, *Changing Veteran Population*.

Table 3.5 Projected Veteran Population, 2006–2030

GROUP	NUMBER OF VETERANS			
	2006	2010	2020	2030
Total	23,976,991	22,148,322	18,120,496	15,155,603
Age				
18–29	1,072,207	1,045,491	979,419	982,645
30–39	2,159,502	1,841,471	1,755,975	1,696,527
40–49	3,483,934	3,149,685	2,072,688	2,005,472
50–64	8,060,978	7,192,188	4,944,876	3,490,641
65–84	8,125,036	7,635,813	7,229,123	5,878,456
85+	1,075,334	1,283,674	1,138,415	1,101,861
Gender				
Male	22,245,866	20,374,164	16,234,771	13,152,632
Female	1,731,125	1,774,158	1,885,725	2,002,971
Period of service				
Gulf War	4,297,284	5,042,553	5,489,107	5,425,080
Vietnam Era	7,286,528	6,909,650	5,359,785	3,018,058
Korean War	2,530,634	1,986,831	660,582	64,458
World War II	2,821,966	1,642,282	184,166	3,067

SOURCE: VA Office of Policy and Planning. "Veteran Population Model," *VetPop 2004*, Version 1.0. Washington, DC: VA, 2007.

III.2 Greater Proportion of Female Veterans

The presence of women among the veteran population will become more pronounced during the next several decades. Thus, while the total number of veterans will drop by about 25 percent, women will account for more than 10 percent of the veteran population in 2020, up from 7 percent in 2006.¹²⁰ DoD projects that the percentage of women will continue to increase — especially African-American women, which will increase at greater rate than that of African-American men.

III.3 Increased Ethnic and Racial Diversity

Census data project more ethnic diversity among older Americans by 2050 (Table 3.6); the population of veterans will likely reflect these ethnographic shifts. Caucasians are the only group expected to decrease proportionally, and by a

¹²⁰ VA, *Veteran Population Model*.

remarkable 20 percent. Meanwhile, the greatest growth—10 percent—will occur among Hispanics.

Table 3.6 Proportions of Older Americans by Origin

ORIGIN	PERCENTAGE IN 2000 (%)	PERCENTAGE PROJECTED FOR 2050 (%)
Caucasian	84	64
Black	8	12
Hispanic	6	16
Asian	2	7

SOURCE: U.S. Census Bureau. *Census 2000, National Institute on Aging Portfolio for Progress* (02-4995). Washington, DC: Census Bureau, 2001, 43.

IV Summary

For 400 years, America has cared for its veterans. The U.S. has provided compensation, pension, health care, rehabilitation, education, insurance, loans, burial, and other benefits that have reflected the economic, cultural, and political climates of the times. The meaning of being a “grateful nation” has been debated, legislated, and revised as each generation of veterans has returned home. The systems to assist disabled veterans today exist as a result of struggles and challenges faced by veterans of the past. VA’s preparations for the veterans of today and tomorrow should reflect the changing composition and concerns of present and future service members.

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Rating Process and System

I VA Schedule for Rating Disabilities

I.1 Introduction

The Department of Veterans Affairs (VA) has a disability evaluation guide called the Schedule for Rating Disabilities (hereafter referred to as the “Rating Schedule”). The Rating Schedule is a key component in the process of adjudicating claims for disability compensation. It is used to assess the severity of disability. In turn, the severity, expressed as a percentage of disability, or rating, determines the amount of monthly compensation (Table 4.1).

The Rating Schedule consists of slightly more than 700 diagnostic codes organized under 14 body systems, such as the musculoskeletal system, organs of special sense, and mental disorders. For each code, the schedule provides criteria for assigning a percentage rating. The criteria are primarily based on loss or loss of function of a body part or system, as verified by medical evidence, although the criteria for mental disorders are based on the individual’s “social and industrial inadaptability,” i.e., overall ability to function in the workplace and everyday life. The ratings may range from 0 percent to 100 percent, or total, in intervals of 10 percent, although in most cases, a smaller number of percentages is used. Mental disorders, for example, may be rated 0, 10, 30, 50, 70, or 100 percent. The schedule includes procedures for rating conditions that are not among the 700 plus diagnostic codes. It also includes procedures for combining ratings into a single overall rating when a veteran has more than one disability.

Table 4.1 2007 Disability Compensation Amounts

COMBINED RATING	COMPENSATION			
	Veteran Alone	Veteran with Spouse	Veteran, Spouse, and Child	Veteran, Spouse, Two Parents, Child
10%	\$115	\$115	\$115	\$115
20%	\$225	\$225	\$225	\$225
30%	\$348	\$389	\$420	\$486
40%	\$501	\$556	\$597	\$685
50%	\$712	\$781	\$832	\$944
60%	\$901	\$984	\$1,045	\$1,179
70%	\$1,135	\$1,232	\$1,303	\$1,459
80%	\$1,319	\$1,430	\$1,511	\$1,689
90%	\$1,483	\$1,608	\$1,699	\$1,899
100%	\$2,471	\$2,610	\$2,711	\$2,935

NOTE: The VA compensation rate table includes additional categories, such as a veteran and two parents, and add-on amounts for additional children under age 18, additional children in school over 18, and spouses requiring aid and attendance.

SOURCE: Compensation Rate Table, Effective 12/1/06. Available at: <http://www.vba.va.gov/bln/21/Rates/comp01.htm> (accessed August 15, 2007).

It is critical that the Rating Schedule be as accurate as possible, so that rating decisions based on it are as valid and reliable—and therefore fair—as possible. Validity means that ratings based on the Rating Schedule reflect the actual degree of disability of the veteran. Reliability means that veterans with the same disability receive the same rating or that two raters would give the same veteran the same rating. Validity and reliability of rating decisions depend on the accuracy of the Rating Schedule in determining degree of disability and on additional factors. Additional factors include the quality and relevance of medical information, accuracy and ease of use of information systems, training and experience of raters, effectiveness of the quality review system, and number of raters and other personnel involved in the claims adjudication process. These issues are addressed later in this report.

This section of the report addresses the effectiveness of the Rating Schedule as a tool for determining degree of disability. But before the schedule's effectiveness can be evaluated, the purposes of the VA disability compensation program must first be specified. As the Commission considered these purposes, several questions presented themselves.

The purpose of compensation as stated in statute is to make up for the average impairment of earning capacity caused by service-connected disabilities. Given this purpose, is the Rating Schedule effective in determining the impairment of earning capacity experienced on average by veterans with the same rating level? Moreover, it is commonly acknowledged that the disability compensation program compensates for injuries and diseases that do not impair earning capacity but have negative consequences for veterans. Therefore, is the purpose of the Rating Schedule to also compensate for noneconomic losses, such as ability to participate in everyday life activities; physical or mental losses that do not have economic impacts; disfigurement; or shorter life spans? If so, how effective is the schedule for providing compensation for these noneconomic losses? Should the Rating Schedule compensate for overall loss of quality of life?

The origins and historical development of the Rating Schedule are described next, because the current schedule has been strongly shaped by earlier schedules. The history is followed by a review of the findings on the currency of the current schedule in the Institute of Medicine's report, *A 21st Century System for Evaluating Veterans for Disability Benefits*, and the Commission's findings and recommendations on the medical adequacy of the Rating Schedule. The chapter then turns to the assessment of the medical evaluation and rating determination processes in the IOM report and the improvements recommended in that report, followed by the Commission's recommendations.

I.2 Historical Origins and Development

The present Rating Schedule was developed in 1945 and was based on revisions of schedules dating from 1917.¹ Since 1917, the head of VA has been directed to adopt and apply a schedule of ratings based "as far as is practicable upon the average impairments in earning capacity . . . in civil occupations."² The economic purpose of the Rating Schedule was amplified in the first revision of the law in 1919, when an additional sentence directed the bureau during the development of the Rating Schedule to consider "the impairment in ability to secure employment" resulting from permanent injury (Pub. L. No. 104, (1919). According to statute, the secretary "shall from time to time readjust this schedule of ratings in accordance with experience" (38 U.S.C. § 1155). The first official

¹ President's Commission, *Administration of Veterans' Benefits*, 33. A "Provisional Rating Table" was issued in September 1919, although it was never approved officially.

² Compensation was first authorized by the War Risk Insurance Act of 1917, Pub. L. No. 90 (1917). Before the present Department of Veterans Affairs was established in 1989, veterans' compensation was administered by the heads of the Bureau of War Risk Insurance (1917–1921), Veterans' Bureau (1921–1930), and Veterans Administration (1930–1989), respectively.

rating schedule was promulgated in 1921, and comprehensive revisions of the schedule were made in 1925, 1933, and 1945.³

The U.S. veterans' disability compensation program was implemented soon after workers' compensation programs were established at the state and federal levels, and the programs have similarities as well as important differences.⁴ Both programs were intended to compensate for disability (i.e., the consequences of injury), not for injury itself (although in practice, degree of loss has often been used as a proxy for degree of disability). In both programs, disability was limited to economic loss, not to all damages—physical, mental, and social as well as economic—allowed under common law. The two programs were also alike, except in a few states, in using schedules based on the average loss of earning capacity of beneficiaries with similar impairments, rather than on the actual loss of earning capacity of each individual claimant.

A major difference between the programs as they have evolved has been the basis for compensation. Workers' compensation programs in the United States, which compensate for injuries and diseases caused by work, have remained based on loss of wages, while the veterans' disability compensation program, which compensates for injuries and diseases acquired while in national military service, has expanded the basis for compensation over time to include noneconomic losses. For example, the disability compensation program pays additional reparations for certain severe conditions, such as the loss of both hands or both feet.⁵ Another difference is in the duration of payments. Workers' compensation programs typically pay a fixed amount for a given impairment, calculated as a percentage of the injured worker's pay (usually two-thirds) for a certain number of weeks; VA compensation is paid monthly for life.

I.2.A First Official Rating Schedule: 1921

According to the 1921 Rating Schedule, "A disability is considered to be a mental or physical condition which would cause to the average person an impairment of earning capacity in civil occupation."⁶ Although the Rating Schedule was intended to measure degree of disability associated with impairment of earning capacity, the 1921 authors had little information on the relationship between degree of disability and earnings on which to base the schedule. They drew on the practices of workers' compensation programs and private disability insurance companies, but these were only a few years old and had accumulated little practical experience. The law recognized this situation by directing that the

³ A "Provisional Rating Table" was issued in September 1919, although it was never approved officially.

⁴ President's Commission, "Veterans' Administration Contrasted."

⁵ Called "special monthly compensation."

⁶ Veterans' Bureau, *Disability Rating Table*, 5.

Rating Schedule be readjusted from time to time based on actual program experience (War Risk Insurance Act of 1917, Pub. L. No. 90). The developers of the first schedule also consulted leading medical experts in the United States and the schedules for rating veterans used in France, Canada, England, and Belgium.⁷

In line with then-prevailing concepts, the schedule was based on the idea that a whole person who suffers injury or illness with permanent effects loses a percentage of his or her capacity. This was made explicit in the procedure adopted for combining multiple rating percentages, which was used to construct the combined ratings table in the 1921 schedule that is still used today. For example, if a veteran has two disabilities rated 50 and 30 percent, the combined rating is 65 percent. This is determined as follows: The highest rating is subtracted from 100 percent first, leaving the veteran in this case with 50 percent capacity. The 50 percent remaining capacity is then reduced by the next highest rating, in this case, 30 percent ($50 - (.3 \times 50)$), leaving him or her with 35 percent capacity and a combined rating of 65 percent (100 percent minus 35 percent). Any additional disabilities, if there are any, are applied against the remaining 35 percent, starting with the highest remaining rating, until all disabilities are accounted for.⁸ After all disabilities have been considered and combined, the combined value is “then converted to the nearest number divisible by 10, and the combined values ending in 5 will be adjusted upward” (38 C.F.R. § 4.25(a)). So, in this example, the combined rating would be adjusted upward to 70 percent.

The 1921 schedule also reflected then-prevailing practice in using degree of impairment of a body part or system as the measure of disability, because tools to measure the impacts of impairment on a person’s ability to work did not exist. Thus the schedule tied the degree of disability to the extent that a body part was missing or unusable, not on how well the average person could accomplish work-related functions given their impairments. For example, the percent disability caused by amputation of an arm or thigh was based on the amount of limb lost. The percent disability caused by impairment of a limb was based on the amount of range of motion lost, and the percent disability caused by impairment of vision was based on degree of refractive error (Table 4.2) (e.g., 0 percent for 20/40 in both eyes, 100 percent for less than 10/200 in both eyes).

⁷ Veterans’ Bureau, *Disability Rating Table*, 13, 25, 39, 45, 57, 75, 82.

⁸ Beginning with the 1933 schedule, the combined rating is rounded to the nearest number divisible by 10 and ratings ending in 5 are rounded up. Thus, in the example given above, the combined rating of 65 would be rounded up to 70.

Table 4.2 Reproduced Excerpt of 1921 Rating Schedule

DISABILITY	MAJOR ^a	MINOR ^a
Arm, amputation of		
Disarticulation (total)	94%	85%
Upper and middle third	89%	80%
Lower third	84%	75%
Thigh, amputation of	EITHER	
Disarticulation (total)	80%	
Upper third	80%	
Middle third	63%	
Lower third	58%	
	MAJOR	MINOR
Forearm, limitation of flexion of		
50° (160°–110°)	25%	20%
70° (160°–90°)	20%	15%
110° (180°–70°)	5%	5%

^a Major and minor refer to handedness, i.e., the major arm of a right-handed person is his or her right arm, and the minor arm is his or her left arm.

I.2.B 1925 Rating Schedule

The 1925 Rating Schedule was developed in response to a change in the law in 1924, which added “similar to the occupation of the injured man at the time of enlistment” to the original standard, “The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations.” Accordingly, the 1925 schedule included a method to adjust the ratings in accord with the physical and mental demands of each claimant’s occupation. Under the 1925 schedule, two veterans with the same percentage of impairment would receive different amounts of compensation depending on their occupation. For example, a musician who lost a finger would receive more compensation than an accountant. The impairment table was developed primarily by a medical expert; the occupational table was developed by a panel of occupational specialists.⁹ They were assisted by experts who designed the California Schedule of Rating Permanent Disabilities, by data from the Bureau International du Travail in Geneva, Switzerland, other national and international sources of correspondence, and publications of the

⁹ Director Veterans’ Bureau, *1926 Annual Report*, 46-47.

Departments of the Army, Commerce, and Labor, and the Census Bureau.¹⁰ The Veterans' Bureau's Medical Service established a board of medical, legal, and occupational experts for regional offices to consult about questions arising from application of the schedule and to evaluate and revise the schedule, and a number of revisions were made.¹¹

I.2.C 1933 Rating Schedule

The Rating Schedule was revised twice in 1933. The first revision included only five grades of disability, and each grade had an associated degree rating and a computational value used when there were multiple disabilities. A second revision followed on the heels of the first, and it is this second revision that is commonly called the 1933 Rating Schedule.

The 1933 Rating Schedule returned to the original 1917 concept of average impairment of earning capacity without regard to occupation, but its ratings were derived from the 1925 schedule by using the midrange of the occupational ratings in the 1925 schedule. In some places, the 1933 schedule elaborated on the 1925 schedule, for example, by replacing two ratings for peripheral nerve injuries (complete and partial) with four ratings (complete, severe, moderate, and mild), and by making "social and industrial inadaptability" the measure of psychiatric disability (previously, the measure was just "social inadaptability"). The 1933 schedule was the first to use diagnostic codes. There were seven "extensions" (revisions) to the 1933 schedule before it was superseded by the 1945 schedule.

I.2.D 1945 Rating Schedule

The 1945 Rating Schedule was in turn based on the 1933 schedule, with revisions made by experienced rating personnel (most of them physicians), physicians in VA's Department of Medicine and Surgery, and representatives of the Board of Veterans Appeals and other VA offices.¹² The VA Department of Medicine and Surgery provided the revision group, called the Disability Policy Board, with

a medical monograph—a detailed description of etiology and manifestations—for each of the conditions included in the schedule at that time. The Board used these monographs to estimate the relative effects different levels of severity of a condition have on the

¹⁰ President's Commission, *Disability Rating Schedule: Historical Development*, 43.

¹¹ Weber and Schmeckebier, *Veterans' Administration*, 139.

¹² President's Commission, *Administration of Veterans' Benefits*, 33.

average veteran's ability to compete for employment in the job market. It set disability ratings on this basis.¹³

The revisions were based on consensus because no empirical studies of the average earnings of veterans with different rating levels had been done.

The Chairman of the VA Rating Schedule Board, in a statement dated January 21, 1952, . . . indicated that the 1945 schedule is an outgrowth of other rating schedules which had been in use at various times from 1921 to April 1, 1946. He stated that the disability ratings provided in the 1921 schedule were not calculated on statistical or economic data regarding the average reduction in earning capacities from any disability because such data were not available, and that they undoubtedly represented the opinions of the physicians who had developed the schedules as to the effect of the various disabilities upon the earning capacity of the average man. He also stated that the disability percentage ratings provided in the 1945 schedule are based on very little calculation but that they represent the consensus of informed opinion of experienced rating personnel, for the most part physicians, and reflect many compromises of their views.¹⁴

The 1945 Rating Schedule was reorganized and more detailed than its predecessor, although the basis was the same (average impairment of earning capacity) and the main unit of measurement was still impairment (extent of loss or loss of use of a body part or function). The 1933 schedule had five broad groupings of conditions. The 1945 schedule split musculoskeletal and neurological disorders, and it divided a general medical and surgical disabilities category into a number of body systems—cardiovascular, digestive, gynecological, and so forth—for a total of 14 body systems. The eye, ear, nose, and throat category became the organs of special sense, after nose and throat disorders were moved into the new respiratory system. The diagnoses were renumbered in separate series under each body system, so that, for example, the codes for musculoskeletal disorders began with 5000, the codes for vision impairment began with 6000, and so forth, through the codes for dental and oral conditions, which began with 9900 (Table 4.3).

¹³ Government Accountability Office, *Need to Update*, 11.

¹⁴ President's Commission, *Disability Rating Schedule: Historical Development*, 33.

Table 4.3 Rating Schedule Body Systems and Diagnostic Code Series

BODY SYSTEM	BODY SUBSYSTEM	DIAGNOSTIC CODE SERIES
Musculoskeletal	Acute, subacute, or chronic diseases	5000
	Amputations and loss of use of extremities	5100
	Ankyloses, limitation of motion, and other impairments of joints and bones	5200
	Muscle injuries	5300
Organs of special sense	Eye	6000
	Hearing	6100
	Ear and other sense organs, diseases of	6200
Systemic conditions ^a		6300
Respiratory	Nose and throat	6500
	Trachea and bronchi	6600
	Lungs and pleura	6700
Cardiovascular	Heart	7000
	Arteries and veins	7100
Digestive	Mouth and esophagus	7200
	Gastrointestinal	7300
Genitourinary		7500
Gynecological conditions		7600
Hemic and lymphatic		7700
Skin		7800
Endocrine		7900
Neurological conditions and convulsive disorders	Central nervous system	8000
	Miscellaneous	8100
	Cranial nerves	8200
	Peripheral nerves, paralysis	8500
	Peripheral nerves, neuritis	8600
	Peripheral nerves, neuralgia	8700
	Epilepsies	8900
Mental disorders		9000
Dental and oral conditions		9900

^a The “systemic conditions” category was renamed “infectious diseases, immune disorders, and nutritional deficiencies” in 1996 (Final Rule: Schedule for Rating Disabilities; Infectious Diseases, Immune Disorders and Nutritional Deficiencies (Systemic Conditions), 61 FR 39,873 [July 31, 1996]).

The new 1945 Rating Schedule had approximately 700 diagnostic codes, compared with the 500 in the 1933 schedule. The increase in the number of codes included mostly new conditions, but about 60 resulted from assigning separate codes to (1) each combination of fingers, (2) neuritis and neuralgia of each of the 21 peripheral nerves, and (3) to 25 combinations of injuries also entitled to special monthly compensation.

I.3 History of Revisions of the 1945 Rating Schedule

The 1945 Rating Schedule became effective on April 1, 1946. The first revision, called an "extension," was issued on July 14, 1947. As with many of the early revisions, extension 1 concerned the rating of tuberculosis, because rapid advances in chemotherapy, beginning with the availability of streptomycin in 1946, were making the criteria for tuberculosis ratings steadily obsolete. By 1956, when the President's Commission on Veterans Pensions (Bradley Commission) reported, there had been 14 extensions, most of them revising a specific section.¹⁵

The Bradley Commission conducted three studies of the Rating Schedule: a survey and analysis of the views of 169 medical specialists on how up to date and valid the schedule was, a survey and comparative analysis of the earnings of more than 12,000 veterans receiving compensation and 7,000 veterans not receiving compensation, and an actuarial study of the mortality rates of veterans receiving compensation. The Commission summarized the results as follows:

The Commission's studies show that the rating standards, presumptions, and follow-up procedures have many inconsistencies and are not in line with present-day medical science. The progression of ratings from degree to degree does not accurately reflect differences in capacity to earn or in longevity. The rates of compensation for those rated totally disabled appear inadequate. There is an overemphasis on obvious disabilities in comparison with equal disabilities which are not so evident. Consideration should be given to incorporating the statutory awards within a comprehensive rating scale that will encompass economic, physical, life impairment, and other factors.¹⁶

The Bradley Commission survey results showed that total median income of veterans with disabilities, including compensation, was 97 percent of the total median income of all veterans, but looked at by age, older veterans (55 years old

¹⁵ President's Commission, *Disability Rating Schedule: Historical Development*, 52.

¹⁶ President's Commission, *Veterans' Benefits*, 13.

and older) with disabilities made only 88 percent of the median income of all veterans in that age group. The survey analysis also compared median earnings plus compensation of veterans with disabilities with the median earnings of all veterans and found that they were about the same for all rating levels except 90 and 100 percent. Those rated 90 percent made about 20 percent more on average than all veterans while those rated 100 percent made 42 percent less.¹⁷

The Bradley Commission recommended that

the Veterans' Administration Schedule for Rating Disabilities should be revised thoroughly so that it will reflect up-to-date medical, economic, and social thinking with respect to rating and compensation of disability...based on thorough factual studies by a broadly representative group of experts, including physicians, economists, sociologists, psychologists, and lawyers.

The Commission recommended that, while impairment of earning capacity should be the “primary factor in the determination of rating criteria,” noneconomic factors should also be considered, such as loss of “physical integrity” (i.e., anatomical losses) not affecting earning capacity, “social inadaptability,” and shortened life expectancy. The Commission also recommended that the rates of compensation should be related to the average earnings of a representative group of workers and adjusted every 2 years “if measurable change has occurred.”¹⁸

The medical specialists who were surveyed identified a number of obsolete terms, rating criteria outmoded by medical advances, and missing diagnoses. Most of these, such as the lack of a code for psychomotor epilepsy and outdated nomenclature for psychoses, have been remedied, but some remain, such as using the number of daily insulin doses as a measure of the degree of disability of a diabetic.¹⁹

In 1961, VA addressed a part of the Rating Schedule largely dating from 1933. The designers of the 1945 schedule had kept the classifications and nomenclature for mental disorders from the 1933 schedule, that is, having two categories of mental disorders—psychoses and psychoneuroses—and using older terms such as dementia praecox for schizophrenia.²⁰ The 1961 revision adopted four classifications of mental disorders: psychotic disorders, organic brain disorders, psychoneurotic disorders, and psychophysiological disorders. The

¹⁷ Ibid., 162.

¹⁸ Ibid., 168, 181.

¹⁹ President's Commission, *Disability Rating Schedule: Historical Development*, 168.

²⁰ Ibid., 162.

1961 revision also updated the nomenclature; added up-to-date diagnoses from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), such as dissociative, conversion, phobic, obsessive-compulsive, and depressive reactions; and dropped outmoded diagnoses, such as neurasthenia and involuntal psychoses.²¹

In 1971, VA submitted the report of a study, "Economic Validation of the Rating Schedule" (ECVARS), to the Senate Committee on Veterans' Affairs.²² By this time, according to ECVARS, there had been 15 revisions of the Rating Schedule since the Bradley Commission, with input from the VA Department of Medicine and Surgery, staff of the congressional committees, and major service organizations.²³

"ECVARS was conducted in response to the Bradley Commission recommendations and recurring criticisms that ratings in the schedule were not accurate."²⁴ The report noted that technological advances had changed the workplace greatly since 1945, which "have placed a lower premium on physical capacity and dexterity....The muscle-oriented society of the World War II era no longer exists, and the instrument that served so well as a yardstick to measure disablement in that era must now be updated and refined."²⁵

ECVARS surveyed the 1967 earnings of 485,000 veterans each receiving compensation for a single disability and compared the median earnings of those with the same rating level for the same disability with a control group of 14,000 veterans not receiving compensation and matched for age, education, and region of residence. The sample size was enough to compare at least one rating level for about 400 diagnostic codes, for a total of about 1,000 comparisons. The data showed that the percentage of earnings loss was less than the percentage rating in 82 percent of the comparisons, more than the percentage rating in 11 percent of the comparisons, and the same or about the same in 7 percent of the comparisons.²⁶ More than half (71 of 110) of the comparisons in which earnings losses exceeded the rating level involved neurological and mental disorders. For example, veterans rated 70 percent for schizophrenia, other psychotic reaction,

²¹ The DSM is promulgated and periodically updated by the American Psychiatric Association and is consistent with, although more detailed than, the *International Classification of Diseases* promulgated by the World Health Organization.

²² U.S. Congress, "Economic Validation." The report was submitted to the Senate Committee on Veterans' Affairs in 1971 but was not published until 1973.

²³ VA, *ECVARS*, 319.

²⁴ Government Accountability Office, *VA Disability Compensation*, 15.

²⁵ VA, *ECVARS*, 323.

²⁶ The "same or about the same" category includes all comparisons in which the earnings loss was between 90 and 110 percent of the rating level, such as between 90 and 110 percent for cases rated 100 percent, between 45 and 55 percent for cases rated 50 percent, and between 9 and 11 percent for cases rated 10 percent.

chronic brain syndrome associated with brain trauma, and anxiety reaction earned on average 85 percent, 77 percent, 83 percent, and 84 percent less, respectively, than veterans without disabilities. After adding compensation to earnings, these veterans still averaged between 51 and 59 percent less than control-group veterans. Veterans rated 90 percent for amputation of an arm had earnings losses of 26 percent. After adding compensation to earnings, these veterans averaged 7 percent more than control-group veterans.

VA revised the Rating Schedule based on the ECVARS findings and submitted it to Congress in 1973. The revised schedule would have raised some ratings and reduced many others. For example, it proposed increasing the 70 percent rating for mental disorders to 80 percent and reducing the rating levels for many musculoskeletal impairments, such as amputation of the arm at the shoulder (from 90 to 60 percent) and amputation of the leg at the hip (from 90 to 40 percent). The revised schedule was not adopted.

After the failure of ECVARS to affect the Rating Schedule, VA's revisions of the schedule "concentrated on improving the appropriateness, clarity, and accuracy of the descriptions of the conditions in the schedule rather than on attempting to ensure that the schedule's assessments of the economic loss associated with these conditions are accurate."²⁷ In 1989, the General Accounting Office (GAO)—now the Government Accountability Office—issued the report *Need to Update Medical Criteria Used in VA's Disability Rating Schedule* based in part on a clinical review of the schedule that was conducted by a group of medical specialists on the faculty of Jefferson Medical College in Philadelphia. The specialists reported that a "major overhaul" was needed to reduce the probability of inaccurate classifications of impairments,²⁸ citing outdated terminology; diagnostic classifications that were outdated, ambiguous, or missing; evaluation criteria made obsolete by medical advances, and out-of-date specifications of laboratory tests.

In response to the 1988 GAO report, VA published its intent to update the entire Rating Schedule in a series of Advance Notices of Proposed Rulemaking (ANPRM) in the *Federal Register* beginning in August 1989. The first ANPRM—to review and update the genitourinary section of the schedule—had the following statements, which appeared in each of the subsequent ANPRMs:

This ANPRM is necessary because of a General Accounting Office (GAO) study and recommendation that the medical criteria in the rating schedule be reviewed and updated as necessary. The

²⁷ Government Accountability Office, *Need to Update*, 33–34.

²⁸ *Ibid.*, 15.

intended effect of this ANPRM is to solicit and obtain the comments and suggestions of various interest groups and the general public on necessary additions, deletions and revisions of terminology and how best to proceed with a systematic review of the medical criteria used to evaluate disabilities of the genitourinary system. Other body systems will be subsequently scheduled for review until the medical criteria in the entire rating schedule has been analyzed and updated . . . this ANPRM is the first step in a comprehensive rating schedule review plan which will ultimately be converted into a systematic, cyclical review process.

(Advance Notice of Proposed Rulemaking, 54 Fed. Reg. 34,531 [August 21, 1989]).

In preparing proposed and final versions of the sections of the Rating Schedule, VA considered the views of Veterans Health Administration clinicians, Veterans Benefits Administration raters, groups of non-VA medical specialists assembled by a contractor, and comments received in response to the ANPRM and Notice of Proposed Rule Making (NPRM).²⁹ Revisions of nine body systems and the muscle injury part of the musculoskeletal system were made final and published in the *Federal Register* between 1994 and 1997. The hearing part of the special senses was finalized in 1999, and a 10th body system, the skin, was finalized in 2002. NPRMs were published for the vision part of the organs of special sense in 1999, the gastrointestinal part of the digestive system in 2000, and the orthopedic part of the musculoskeletal system in 2003, but final rules were never completed.³⁰ The ANPRMs for the neurological and digestive systems were never followed by an NPRM. The part of the schedule on impairment of vision has been updated several times previously, but the digestive, orthopedic, and neurological body systems have not been comprehensively updated since 1945.

I.4 Currency of the Rating Schedule

According to the study of the Schedule for Rating Disabilities conducted for this Commission by the Institute of Medicine (IOM)

The Rating Schedule contains a number of obsolete diagnostic categories, terms, tests, and procedures, and does not recognize

²⁹ Proposed and final versions are Notices of Proposed Rule Making (NPRMs) and Final Rules, respectively, as published in the *Federal Register*. For example, the following responded to the NPRM for revising the mental disorder section: The American Legion, Disabled American Veterans, Veterans of Foreign Wars, Vietnam Veterans of America, American Psychological Association, American Psychiatric Association, Association of VA Chief Psychologists, and a concerned individual.

³⁰ The gastrointestinal and orthopedic NPRMs were formally withdrawn from VA's regulatory agenda in 2004.

many currently accepted diagnostic categories....In other cases, the diagnostic categories are current but do not specify appropriate procedures to measure disability for the conditions.

The IOM report identified examples of conditions in need of updating, including craniocerebral trauma (because, for example, a number of chronic effects are not included), neurodegenerative disorders (because some currently known disorders are not included while some disorders now known to be autoimmune are included), spinal cord injury (because it relies on an outmoded classification system), posttraumatic arthritis (because it requires x ray rather than more up-to-date imaging techniques that provide much more information, such as computerized tomography [CT] and magnetic resonance imaging [MRI]), and mental disorders (because the rating criteria are based on sets of symptoms that do not apply to all mental disorders).³¹ Another IOM report reached a similar conclusion regarding posttraumatic stress disorder (PTSD), namely, that the rating criteria were not appropriate for PTSD because they included some symptoms consistent with other mental disorders but not PTSD.³²

The problem with evaluating disability caused by PTSD stems from the decision in the 1996 revision of the mental disorders section of the Rating Schedule to use a single rating formula to rate all mental conditions except eating disorders.³³ The 1961 revision of the mental disorders section had increased the classifications of disorders from two to four; the 1996 revision reclassified the conditions into eight categories to “conform more closely to the categories in DSM–IV, thus making it easier for rating specialists to correlate the diagnoses given on VA and non-VA exams with the conditions in the rating schedule” (Proposed Rule: Schedule for Rating Disabilities; Mental Disorders, 60 Fed. Reg. 54,825 [(October 26, 1995)]. But in place of three rating formulas in the 1961 revision—for psychotic disorders, organic mental disorders, and psychoneurotic disorders—VA proposed a single rating formula with the intent of “providing objective criteria based on signs and symptoms that characteristically produce a particular level of disability.”

General Rating Formula for Mental Disorders

Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory

³¹ Institute of Medicine, *21st Century System*, 93–95.

³² Institute of Medicine, *PTSD Compensation*, 156–157, 162.

³³ VA, *Schedule*, Box VI.3.C-1.

loss for names of close relatives, own occupation, or own name.....	100
Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately, and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships.....	70
Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships.....	50
Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events).....	30
Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or symptoms controlled by continuous medication.....	10
A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication.....	0

A commenter responding to the NPRM suggested adopting separate rating formulas tailored to each psychiatric disorder. Another commenter suggested

that PTSD be evaluated under a separate formula based on the frequency of symptoms particular to PTSD, such as nightmares, flashbacks, troubling intrusive memories, uncontrollable rage, and startle response. A third commenter noted that the proposed criteria for a 100 percent rating included more symptoms of thought disorders than of mood disorders, which might make mood disorders less likely than thought disorders to be evaluated as totally disabling (Final Rule: Schedule for Rating Disabilities; Mental Disorders, 61 Fed. Reg. 52,695 [October 8, 1996]).

VA decided to stay with the single rating formula, because a single formula would be “a better way to assure that mental disorders producing similar impairment will be evaluated consistently.” In the Final Rule, VA stated that the symptoms in the rating formula are “representative examples of symptoms that often result in specific levels of disability,” and indeed the rating formula refers to “such symptoms as,” which implies that these are the kinds of symptoms to consider in deciding on a percentage rating, not that each of them must be present in one person to assign the rating. Thus, for example, in rating someone with a mood disorder, VA’s response was that veterans with mood disorders who demonstrate grossly inappropriate behavior, persistent danger of hurting self or others, or intermittent inability to perform activities of daily living—which are three of the representative symptoms listed for a 100 percent rating—would clearly support a rating of total disability, even though they do not exhibit other symptoms, such as gross impairment in thought processes or delusions or hallucinations.

The fundamental problem with the general rating scale for mental disorders is the weak nexus between severity of symptoms and degree of social and occupational disability, which makes the inclusion of symptoms in the criteria problematic in terms of determining disability. The mixing of symptoms and functional measures is also a weakness of the Global Assessment of Functioning Scale, which was criticized in the IOM report, *PTSD Compensation and Military Research*, which recommends looking at symptoms, function, and other dimensions of PTSD separately.³⁴ There are also practical problems if raters are not able to identify which symptoms are appropriate for evaluating the claimant’s disorder or expect the claimant to exhibit all the symptoms listed for a particular rating level, even though the particular sets of symptoms in the general rating scale were chosen to be representative of various disorders.

The IOM report found that the current criteria under diagnostic code 8045 for rating craniocerebral trauma, commonly called traumatic brain injury (TBI), are not adequate for rating all conditions in this classification, and IOM recommended that the criteria be updated.³⁵ Diagnostic code 8045 was added to

³⁴ Institute of Medicine, *PTSD Compensation*, 90–93, 105–106.

³⁵ Institute of Medicine, *21st Century System*, 93.

the Rating Schedule in 1961 and has not changed substantively since that time.³⁶ The Rating Schedule entry for 8045 currently reads:

8045 Brain disease due to trauma:

Purely neurological disabilities, such as hemiplegia, epileptiform seizures, facial nerve paralysis, etc., following trauma to the brain, will be rated under the diagnostic codes specifically dealing with such disabilities, with citation of a hyphenated diagnostic code (e.g., 8045-8207).

Purely subjective complaints such as headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma, will be rated 10 percent and no more under diagnostic code 9304 [Dementia due to head trauma]. This 10 percent rating will not be combined with any other rating for a disability due to brain trauma. Ratings in excess of 10 percent for brain disease due to trauma under diagnostic code 9304 are not assignable in the absence of a diagnosis of multi-infarct dementia associated with brain trauma.

TBI per se is not rated directly; rather, it is rated according to the resulting impairments. The guidance at 8045 gives hemiplegia, epileptiform seizures, and facial nerve paralysis, which are physical effects, as examples of conditions that could be rated. The guidance limits a rating based on symptoms such as headache, dizziness, and insomnia, to 10 percent. This made sense in 1961, because the deleterious effects of even mild brain trauma on a person's cognitive and emotional condition, and the negative impacts of these effects on social and occupational functioning, were not well understood. Today, postconcussional effects are recognized and under intense study. The proposed clinical management edition of the *International Classification of Diseases*, tenth revision (ICD-10) include criteria for postconcussional syndrome. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) identifies postconcussional disorder as a potential diagnosis depending on further research.³⁷ The clinical criteria for postconcussional syndrome in ICD-10 would call for a history of TBI and the presence of three or more of the following eight symptoms: (1) headache, (2) dizziness, (3) fatigue, (4) irritability, (5) insomnia, (6) concentration difficulty, (7) memory difficulty, and (8) intolerance of stress, emotion, or alcohol. The DSM-IV criteria are: (1) a history of TBI causing "significant cerebral concussion"; (2) cognitive deficit in attention, memory, or both; (3) presence of at least three of eight symptoms—fatigue, sleep disturbance, headache, dizziness, irritability, affective disturbance, personality change, or apathy—that appear after injury and persist for 3 months; (4)

³⁶ In 1976, tinnitus was deleted from the list of subjective complaints recognized as symptomatic of brain trauma; in 1989, the term "chronic brain syndrome" was replaced by "multi-infarct syndrome" when diagnostic code 9306 was renamed "multi-infarct dementia due to causes other than arteriosclerosis" in the mental disorders section.

³⁷ Boake et al., "Diagnostic Criteria."

symptoms that begin or worsen after injury; (5) interference with social role functioning; and (6) exclusion of dementia due to head trauma or other disorders that better account for the symptoms.

Currently, the Rating Schedule criteria for TBI do not refer to evaluation of cognitive and emotional impacts through structured clinical interviews or neuropsychological testing. Such impacts may be the only manifestations of closed-head TBIs. The guide for VA clinicians performing compensation and pension (C&P) examinations and the worksheet for brain and spinal cord examinations do not provide guidance for assessments of the cognitive effects of TBI (although the worksheet calls for a detailed description of any psychiatric manifestations).^{38,39}

In addition to rating criteria for PTSD and TBI, rating criteria for other conditions are in need of updating as well. For example, two sections of the schedule have not been updated for some time, as indicated by the presence of obsolete terms identified by Jefferson Medical College clinicians in 1988. Examples of such terms include “encephalitis,” “epidemic,” and “chronic” (diagnostic code 8000) and “paramyoclonus multiplex” (diagnostic code 8104) in the neurological conditions section and “gastritis,” and “hypertrophic” (diagnostic code 7307) in the digestive system section.

The IOM report pointed out that the Rating Schedule should be up to date medically to ensure that:

- The diagnostic categories reflect the classification of injuries and diseases currently used in health care, so that the appropriate condition in the Rating Schedule can be more easily identified and confirmed using the medical evidence;
- the criteria for successively higher rating levels reflect increasing degrees of anatomic and functional loss of body structures and systems (i.e., impairment), so that the greater the extent of loss, the greater the amount of compensation; and
- current standards of practice in assessment of impairment are followed and appropriate severity scales or staging protocols are used in evaluating the veteran and applying the rating criteria.

The IOM report recommended that VA update the current Rating Schedule immediately, beginning with those body systems that have gone the longest without a comprehensive update. IOM also recommended that VA adopt a regular process for keeping the schedule updated and establish an external

³⁸ VA, *C&P Service Clinician's Guide*.

³⁹ VA, *Brain and Spinal Cord*.

advisory committee of disability experts to assist in the updating process.⁴⁰ The report suggests that after the Rating Schedule is comprehensively revised, it should be revised every 10 years thereafter.

I.5 Commission Findings and Recommendations on the Medical Adequacy of the VA Schedule for Rating Disabilities

The Commission is in general agreement with the findings and most of the recommendations of the Institute of Medicine. The Commission agrees that the Rating Schedule is out of date in important respects and that VA has neither an adequate system for keeping the medical criteria in the Rating Schedule up to date nor the resources to create such a system.⁴¹

The IOM's *A 21st Century System for Evaluating Veterans for Disability Benefits* report recommendations endorsed by the Commission are:

Recommendation 4.1

The purpose of the current veterans disability compensation program as stated in statute currently is to compensate for average impairment in earning capacity, that is work disability. This is an unduly restrictive rationale for the program and is inconsistent with current models of disability. The veterans disability compensation program should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss in quality of life. (Specific recommendations on approaches to evaluating each consequence of service-connected injuries and diseases are in *A 21st Century System for Evaluating Veterans for Disability Benefits*, Chapter 4.) [IOM Rec. 3-1]

Recommendation 4.2

VA should compensate for nonwork disability, defined as functional limitations on usual life activities, to the extent that the Rating Schedule does not, either by modifying the Rating

⁴⁰ Institute of Medicine, *21st Century System*, 97. Again, the IOM committee on PTSD compensation offered a consistent recommendation, which is for VA to revise the rating criteria for PTSD (IOM, *PTSD Compensation*, 162).

⁴¹ Institute of Medicine, *21st Century System*, 92–131.

Schedule criteria to take account of the degree of functional limitation or by developing a separate mechanism. [IOM Rec. 4-5]

Recommendation 4.3

VA should determine the feasibility of compensating for loss of quality of life by developing a tool for measuring quality of life validly and reliably in the veteran population, conducting research on the extent to which the Rating Schedule already accounts for loss in quality of life, and, if it does not, developing a procedure for evaluating and rating loss of quality of life in veterans with disabilities. [IOM Rec. 4-6]

Recommendation 4.4

VA should develop a process for periodic updating of the disability examination worksheets. This process should be part of, or closely linked to, the process recommended above for updating and revising the Schedule for Rating Disabilities. There should be input from the disability advisory committee recommended above (see IOM Rec. 4-1). [IOM Rec. 5-1]

Recommendation 4.5

VA should mandate the use of the online templates that have been developed for conducting and reporting disability examinations. [IOM Rec. 5-2]

Recommendation 4.6

VA should establish a recurring assessment of the substantive quality and consistency, or inter-rater reliability, of examinations performed with the templates and, if the assessment finds problems, take steps to improve quality and consistency, such as revising the templates, changing the training, or adjusting the performance standards for examiners. [IOM Rec. 5-3]

Recommendation 4.7

The rating process should have built-in checks or periodic evaluations to ensure inter-rater reliability as well as the accuracy and validity of rating across impairment categories, ratings, and regions. [IOM Rec. 5-4]

Recommendation 4.8

VA raters should have ready access to qualified health care experts who can provide advice on medical and psychological issues that arise during the rating process (e.g., interpreting evidence or assessing the need for additional examinations or diagnostic tests). [IOM Rec. 5-5]

Recommendation 4.9

Educational and training programs for VBA raters and VHA examiners should be developed, mandated, and uniformly implemented across all regional offices with standardized performance objectives and outcomes. These programs should make use of advances in adult education techniques. External consultants should serve as advisors to assist in the development and evaluation of the educational and training programs. [IOM Rec. 5-6]

Recommendation 4.10

VA and the Department of Defense should conduct a comprehensive multidisciplinary medical, psychological, and vocational evaluation of each veteran applying for disability compensation at the time of service separation. [IOM Rec. 6-1]

Recommendation 4.11

VA should sponsor research on ancillary benefits and obtain input from veterans about their needs. Such research could include conducting intervention trials to determine the effectiveness of ancillary services in terms of increased functional capacity and enhanced health-related quality of life. [IOM Rec. 6-2]

Recommendation 4.12

The concept underlying the extant 12-year limitation for vocational rehabilitation for service-connected veterans should be reviewed and, when appropriate, revised on the basis of current employment data, functional requirements, and individual vocational rehabilitation and medical needs. [IOM Rec. 6-3]

Recommendation 4.13

VA should develop and test incentive models that would promote vocational rehabilitation and return to gainful employment among veterans for whom this is a realistic goal. [IOM Rec. 6-4]

Recommendation 4.14

In addition to medical evaluations by medical professionals, VA should require vocational assessment in the determination of eligibility for Individual Unemployability (IU) benefits. Raters should receive training on how to interpret findings from vocational assessments for the evaluation of IU claims. [IOM Rec. 7-1]

Recommendation 4.15

VA should monitor and evaluate trends in its disability program and conduct research on employment among veterans with disabilities. [IOM Rec. 7-2]

Recommendation 4.16

VA should conduct research on the earnings histories of veterans who initially applied for Individual Unemployability benefits past the normal age of retirement under the Old Age, Survivors, and Disability Insurance Program under the Social Security Act. [IOM Rec. 7-3]

Recommendation 4.17

Eligibility for Individual Unemployability should be based on the impact of an individual's service-connected disabilities, in combination with education, employment history, and the medical effects of that individual's age on his or her potential employability. [IOM Rec. 7-4]

Recommendation 4.18

VA should implement a gradual reduction in compensation to recipients of Individual Unemployability benefits who are able to return to substantial gainful employment rather than abruptly terminate their disability payments at an arbitrary level of earnings. [IOM Rec. 7-5]

Recommendation 4.19

VA should adopt a new classification system using the codes from the *International Classification of Disease (ICD)* and the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. This system should apply to all applications, including those that are denied. During the transition to ICD and DSM codes, VA can continue to use its own diagnostic codes, and subsequently track and analyze them comparatively for trends affecting veterans and for program planning purposes. Knowledge of an applicant's ICD or DSM codes should help raters, especially with the task of properly categorizing conditions. [IOM Rec. 8-1]

Recommendation 4.20

Considering some of the unique conditions relevant for disability following military activities, it would be preferable for VA to update and improve the Rating Schedule on a regular basis rather than adopt an impairment schedule developed for other purposes. [IOM Rec. 8-2]

Recommendation 4.21

VA should seek the judgment of qualified experts, supported by findings from current peer-reviewed literature, as guidance for adjudicating both aggravation of preservice disability and Allen aggravation claims. Judgment could be provided by VHA examiners, perhaps from VA centers of excellence, who have the appropriate expertise for evaluating the condition(s) in question in individual claims. [IOM Rec. 9-1]

Recommendation 4.22

VA should guide clinical evaluation and rating of claims for secondary service connection by adopting specific criteria for determining causation, such as those cited above (e.g., temporal relationship, consistency of research findings, strength of association, specificity, plausible biological mechanism). VA should also provide and regularly update information to compensation and pension examiners about the findings of epidemiological, biostatistical, and disease mechanism research concerning the secondary consequences of disabilities prevalent among veterans. [IOM Rec. 9-2]

The Commission rejected the following IOM recommendations and has replaced them with their own interpretations of the findings and offers its rationale. The Commission rejected:

IOM Recommendation 4-1. VA should immediately update the current Rating Schedule, beginning with those body systems that have gone the longest without a comprehensive update, and devise a system for keeping it up to date. VA should reestablish a disability advisory committee to advise on changes in the Rating Schedule.

The Commission takes exception to updating the Rating Schedule by beginning with the body systems that have gone the longest without change. It believes there are more urgent body systems that have come to the forefront as problematic (e.g., traumatic brain injury, mental health/PTSD) and those should be given primary consideration.

IOM Recommendation 4-2. VA should regularly conduct research on the ability of the Rating Schedule to predict actual loss in earnings. The accuracy of the Rating Schedule to predict such losses should be evaluated using the criteria of horizontal and vertical equity.

IOM recommendation 4-3. VA should conduct research to determine if inclusion of factors in addition to medical impairment, such as age, education, and work experience, improves ability of the Rating Schedule to predict actual losses in earnings.

IOM Recommendation 4-4. VA should regularly use the results from research on the ability of the Rating Schedule to predict actual losses in earnings to revise the rating system, either by changing the rating criteria in the Rating Schedule or by adjusting the amounts of compensation associated with each rating degree.

In reviewing IOM's recommendations 4-2 to 4-4, the Commission finds that VA's Rating Schedule and disability compensation system are not designed nor intended to predict actual loss of earnings, so could not accept the premise with which those recommendations were made..

The Commission does agree with the IOM's recommendation that VA undertake a comprehensive update of the Rating Schedule, devise a system for keeping it up to date, and establish a disability advisory committee to assist in the updating process.⁴² The Commission prefers, however, to give highest priority to updating the evaluation and rating of mental disorders, especially PTSD, and traumatic brain injury as the first order of business, because of their prevalence among veterans currently returning from the Global War on Terror.. The Commission also believes that five years is a realistic timetable for completing the comprehensive update of the schedule. The Commission agrees that a disability advisory committee to advise on diagnostic classifications, medical criteria, terminology, and requirements for medical tests and examinations for every body system would be appropriate.

Recommendation 4.23

VA should immediately begin to update the current Rating Schedule, beginning with those body systems addressing the evaluation and rating of post-traumatic stress disorder, other mental disorders, and traumatic brain injury. Then proceed through the other body systems until the Rating Schedule has been comprehensively revised. The revision process should be completed within 5 years. VA should create a system for keeping the Rating Schedule up to date, including a published schedule for revising each body system.

II Evaluation and Rating Process

II.1 Introduction

The Veterans Benefits Administration (VBA) is responsible for processing claims for veterans' disability compensation. VA's strategic goal 1 is to "Restore the capability of veterans with disabilities to the greatest extent possible, and improve the quality of their lives and that of their families."⁴³ VA's strategic plan includes objectives under each goal, the most relevant of which is objective 1.2:

⁴² IOM Recommendation 4-1 from *A 21st Century System for Evaluating Veterans for Disability Benefits* (p.115) reads: "VA should immediately update the current Rating Schedule, beginning with those body systems that have gone the longest without a comprehensive update, and devise a system for keeping it up to date. VA should reestablish a disability advisory committee to advise on changes in the Rating Schedule."

⁴³ VA, *Strategic Plan 2006-2011*, 18.

“Provide timely and accurate decisions on disability compensation claims to improve the economic status and quality of life of service-disabled veterans.”⁴⁴

At the request of the Commission, the IOM Committee on Medical Evaluation of Veterans for Disability Compensation reviewed the (1) medical evaluation processes and (2) rating determination processes, and recommended improvements.

II.2 Medical Evaluation

The rating decision is based primarily on the nature and extent of the veteran’s medical condition. The key medical parts of the disability determination process are:⁴⁵

- development of medical evidence, such as information about degree of impairment, functional limitation, and disability;
- the rating process, in which the medical evidence is compared with the criteria in the Rating Schedule and a percentage rating is determined; and
- the appeal process, in which the adequacy and meaning of the medical evidence is often the central question.

The quality of medical information critically affects the timeliness, accuracy, and consistency of decisions on claims. VBA must request the correct information needed from the medical examiners, examiners must conduct thorough examinations and report the results completely and accurately, and raters must interpret the medical information correctly in light of the criteria in the Rating Schedule.

II.2.A Update Compensation & Pension Examination Templates on a Regular Basis

In addition to submitting their past medical records, nearly every veteran applying for disability compensation is examined by a physician or other appropriate clinician (e.g., psychologist, audiologist) working for or under contract to VA. A series of investigations of the claims process in the 1990s found serious problems with completeness and timeliness of these compensation and pension (C&P) examinations. The Veterans Benefits Administration (VBA), Board of Veterans Appeals (BVA), and Veterans Health Administration (VHA) have worked to improve this process, but the IOM report concluded that more needs to be done. IOM called for stronger implementation of the improved procedures that have been developed by VBA and VHA under the auspices of the Compensation

⁴⁴ Ibid, 18.

⁴⁵ Institute of Medicine, *21st Century System*, 115-116.

and Pension Examination Program (CPEP) established by VBA and VHA in 2001 to improve the examination process. For example, VA has developed C&P examination worksheets to guide examiners, but VA does not systematically update the C&P examination worksheets and some—developed as long ago as 10 years—are seriously out of date. The IOM accordingly recommended that VA have a process for updating the worksheets on a regular basis:

IOM Recommendation 5-1. VA should develop a process for periodic updating of the disability examination worksheets. This process should be part of, or closely linked to, the process recommended above for updating and revising the Schedule for Rating Disabilities. There should be input from the disability advisory committee recommended above (see IOM Recommendation 4-1).⁴⁶

II.2.B Require the Use of C&P Examination Templates

Subsequent to developing the examination worksheets, CPEP developed online templates for completing and reporting the examination worksheets. Although use of the online templates has increased rapidly, examiners are not required to use them, even though early results have shown template examination reports have higher quality than dictated reports, often significantly higher. In addition, template reports were released from 7 to 17 days sooner than dictated reports. Currently, VA is considering mandating their use. The IOM report recommended that VA do so immediately.

IOM Recommendation 5-2. VA should mandate the use of the online templates that have been developed for conducting and reporting disability examinations.

II.2.C Assess and Improve Quality and Consistency of C&P Examinations

VA, through CPEP, has developed a quality assurance process for evaluating C&P examinations. Currently, it is process oriented—meaning, it focuses on whether the information provided on the examination form was complete and timely but not whether it was correct. Independent examinations of a sample of claimants to assess inter-rater reliability are not performed. CPEP reviews a sample of ratings substantively, but the results are not systematically analyzed

⁴⁶ This and all the following IOM recommendations are from the IOM report, *A 21st Century System for Evaluating Veterans for Disability Benefits*.

for general problems or consistency. The IOM report recommended that VA evaluate the substantive quality and consistency of the C&P examinations and make appropriate changes based on the results:

IOM Recommendation 5-3. VA should establish a recurring assessment of the substantive quality and consistency, or inter-rater reliability, of examinations performed with the templates and, if the assessment finds problems, take steps to improve quality and consistency, for example, by revising the templates, changing the training, or adjusting the performance standards for examiners.

II.2.D Commission Recommendations

The Commission concurs with the recommendations in the IOM report for improving the C&P examination process (IOM recommendations 5-1, 5-2, and 5-3). The Commission also recommends that comparable steps be taken with regard to C&P examinations performed by contract providers, which accounted for 16 percent of the examinations in FY 2005.⁴⁷ Their templates should be updated on a regular basis, their use should be mandated, and the substantive quality and consistency of the examinations performed by clinicians used by contract examination companies should be assessed and the results used to improve the examinations.

II.3 Rating Process

When the medical evidence is complete and other needed information (for example, to establish service connection) is included, the file is sent to a rating veterans service representative (RVSR) for rating. The IOM report made several recommendations for improving the rating process.

II.3.A Quality of Rating Decisions

VBA's quality assurance program for rating decisions, Systemic Technical Accuracy Review (STAR), has improved the accuracy rate from 80 percent in FY 2002 to 88 percent in FY 2006. However, the sample is only large enough to determine the aggregate accuracy rate of regional offices. It cannot assess accuracy at the diagnostic code level or even at the body system level, and it does not measure consistency across regional offices. The IOM report concluded that the many sources of variability in decision making make it unlikely that veterans with similar disabilities will be treated similarly if these sources of variability are not addressed and reduced to the extent possible. Variability

⁴⁷ QTC, *Exam Process*.

cannot be totally eliminated, but IOM called for addressing training, guidelines, rater qualifications, and the other sources of variability that can be controlled:

IOM Recommendation 5-4. The rating process should have built-in checks or periodic evaluations to ensure inter-rater reliability as well as the accuracy and validity of rating across impairment categories, ratings, and regions.

The report gave some examples of evaluations that could be conducted:

- VA could have a sample of claims rated by two or more RVSRs and analyze the degree of consistency in the ratings given.
- The same claims could be analyzed by RVSRs using standard procedures and information sources and by raters with access to medical advisers, and the results compared to see if having medical advisers for raters improves decision making.
- A comparison of raters with a medical background, such as nurses and physician assistants, and raters without medical backgrounds would inform decisions about the qualifications of raters.
- VA could sample claims involving the rating of a particular diagnostic code across field offices and analyze inter-rater and inter-regional differences.

In this last example, the next step could be to determine the degree to which regulations, the adjudication manual, and other forms of guidance could be revised to reduce variability. Training or the quality review system could also increase consistency.

IOM also mentioned another approach to reducing unwanted variability in the rating process—the identification and use of best practices.

II.3.B Better Access to Medical Expertise

Sometimes, the raters are able to use an authoritative medical finding, such as a particular test score, to make a rating decision. Over time, however, the evidence is less clear, more complex, and perhaps conflicting. Raters are not required to have medical backgrounds (although some may happen to have relevant education and training), yet they must understand the medical evidence and use judgment, for example, in weighing conflicting medical evidence and opinions, to determine the percentage of disability.

VBA does not have medical consultants or advisers to support the raters. Currently, if a rater encounters conflicting or unclear evidence, he or she must

send the file back to VHA. The IOM report concluded that medical consultants or advisers in VBA would provide raters with needed support, for example, by helping to identify what medical examinations and tests are needed to sufficiently prepare a case for rating or to weigh medical information that seems conflicting or ambiguous.

At one time, VBA and BVA had physicians on three-person rating boards or panels (the other VBA rating board members were a legal expert and a vocational specialist; the other BVA panel members were legal experts). In a series of decisions, the Court of Appeals for Veterans Claims barred physicians from serving as adjudicators, on the grounds that their participation was not fair or impartial. The IOM report pointed out that all other major disability programs (e.g., Social Security, DoD's Disability Evaluation System, the federal employee workers' compensation, and disability retirement) employ physicians as adjudicators or as consultants to adjudicators. At the Social Security Administration, initial decisions are made by a two-person team, one of whom must be a physician or psychologist (known as a "medical consultant") who takes the lead in evaluating the medical evidence.⁴⁸ Medical consultants are adjudicators; they do not have a doctor-patient relationship with the claimant. Like the lay disability evaluator, the other person on the team, the medical consultant is barred from substituting his or her judgment in place of the treating physician's. By law, medical evidence and opinions from treating physicians must be given "controlling weight," except under specified circumstances, such as internal inconsistency or opinions at odds with test and examination results.

The IOM report concluded that VBA should have medical consultants accessible to RVSRs in regional offices to improve the quality and timeliness of rating decisions:

IOM Recommendation 5-5. VA raters should have ready access to qualified health care experts who can provide advice on medical and psychological issues that arise during the rating process (e.g., interpreting evidence, or assessing the need for additional examinations or diagnostic tests).

The report noted that, with modern communications technology, the medical consultants could be located in regional centers or a national center and have access to the claims file, C&P examination report, and VA and DoD electronic medical records.

⁴⁸ In appeal cases, Social Security administrative law judges can have a medical expert at hearings (the claimant or claimant's representative also may question the medical expert).

II.3.C Training of Examiners and Adjudicators

VBA has a training program and is implementing a certification program for veterans service representatives (VSRs), which it plans to extend to RVSRs and decision review officers. Also, with VHA, VBA is implementing a training and certification program for C&P medical examiners. VBA has developed an extensive training program for VSRs to support the certification effort. A centralized 2-week training course is given every quarter to new VSRs, followed by a nationally standardized 23-week training curriculum given at the regional office where they work. Newly hired RVSRs are also provided a nationally consistent training program. A computer-based training program, the Training and Performance Support System, has a series of modules on rating-related topics, including evaluation of disability conditions by body system. VBA also has an extensive training program, part of it given by an on-staff medical adviser. The quality review programs of both VBA and BVA are used to identify training needs, whether on particular topics or at particular regional offices. VBA is not evaluating the effectiveness of its training programs, however.

The IOM report concluded that the training should be more intensive and the training program should be rigorously evaluated:

IOM Recommendation 5-6. Educational and training programs for VBA raters and VHA examiners should be developed, mandated, and uniformly implemented across all regional offices with standardized performance objectives and outcomes. These programs should make use of advances in adult education techniques. External consultants should serve as advisors to assist in the development and evaluation of the educational and training programs.

II.3.D Commission Discussion and Recommendations

The Commission concurs with the recommendations in the IOM report to improve the rating process (IOM recommendations 5-4, 5-5, and 5-6). The recommendation that VBA have medical consultants to advise raters and other adjudicators will require congressional action to guide the Court of Appeals for Veterans Claims in what medical consultants may do (e.g., weigh medical evidence) and may not do (e.g., substitute their opinion for the treating physician's). Medical consultants can assist VSRs and RVSRs in the regional office predetermination units on identifying missing medical evidence, and they can assist RVSRs on the regional office rating teams in evaluating and weighing medical evidence. This will improve and expedite claims decisions.

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5

Policies for Determining Eligibility for Benefits

Program policies, issues, and specific disabilities are the focus of this chapter. In particular, evaluating and assessing veteran status, the standards for determining eligibility for benefits to veterans with disabilities or survivors of veterans whose deaths are attributable to military service are addressed. The distinct issues discussed are:

- Character of discharge
- Line of duty
- Reasonable doubt
- Age as a factor
- Time limit to file
- Presumptions
- Environmental and occupational hazards
 - Agent Orange and blue water veterans
 - Fort McClellan and PCB exposure risks
 - Chemical exposure at Camp Lejeune
- PTSD and other mental health disorders

Veteran status must be proven prior to any review of a claim for benefits. A discharge under other than dishonorable conditions establishes veteran status.

Assessing service connection for disabilities requires that the disability have been incurred in line of duty. If the evidence concerning the incurrence of the disability is not clear but is balanced, then the principle of reasonable doubt requires the granting of service connection. Presently, age may not be considered as a factor in evaluating service-connected disabilities, unemployability, in claims for service connection, or as a basis for total disability ratings.

To protect the veteran and minimize the time it takes to process a claim and to minimize the development burden on both the veteran and the Government,

presumptions have been established. When there is evidence that a condition was experienced by a sufficient cohort of veterans, it is reasonable to presume that all veterans in that cohort have acquired the condition as a result of military service. The Commission asked the Institute of Medicine (IOM) to review the past practices used to establish presumptions and to recommend a framework that would rely on scientific principles.

This chapter closes with a detailed review of three specific environmental and occupational hazards and an examination of the rating criteria for, diagnosis of, and compensation for PTSD and other mental health conditions.

I Program Policies and Issues

I.1 Character of Discharge

I.1.A Issue

Veterans' benefits are generally available to individuals who separate from military service with an honorable discharge, a general discharge, or a discharge under honorable conditions. Veterans' benefits are generally available also to individuals determined by the Department of Veterans Affairs (VA) to have been discharged under conditions other than dishonorable. Health care benefits may be payable, under certain conditions, to an individual who receives an other-than-honorable discharge. A discharge under honorable conditions is binding on VA as to character of discharge (38 C.F.R. 3.12[a] [2006]). Some veterans have multiple periods of service, one of which could have been dishonorable. A dishonorable discharge for one period of service does not negate rights or entitlement earned by virtue of a separate period of honorable service. The Commission considered the appropriateness of this standard.

Eligibility for VA benefits is established for a veteran whose character of discharge at separation from military service is either honorable, general, or under honorable conditions. A dishonorable discharge deprives a claimant of VA benefits for that period of service. Receipt of a dishonorable discharge is not binding on VA if it is determined that the individual was insane when committing the act(s), which resulted in the dishonorable discharge.

Because "veteran" status establishes the standard for the quality of active service that results in eligibility for VA benefits, in cases involving discharges or releases that are neither clearly honorable nor dishonorable, VA must determine the veteran status of such individual based on the facts and circumstances of service. Accordingly, the military's characterization of a discharge or release does not conclusively determine veteran status in all cases.

The term “discharge or release” includes:

- (A) retirement from active military, naval, or air service, and
- (B) the satisfactory completion of the period of active military, naval, or air service for which a person was obligated at the time of entry into such service. Also, in the case of a person who, due to enlistment or reenlistment, was not awarded a discharge or release from such period of service at the time of such completion thereof and who, at such time, would otherwise have been eligible for the award of a discharge or release under conditions other than dishonorable.

Subsection (B), added to 38 U.S.C. 101(18) in 1977, provided new rules for determining certain veterans' eligibility for VA benefits. The legislative history of this provision discloses that Congress was attempting to correct an inequity: veterans were being denied benefits based upon an entire period of service that terminated in a discharge under dishonorable conditions, even though the individuals had successfully completed the period of service to which they had originally agreed. The intent of the change in law was to treat the honorable completion of the original period of obligated service as though it had resulted in a full discharge or release. This resulted in the individual having more than one period of service and the final discharge under dishonorable conditions no longer constituting a bar to receipt of veterans' benefits based on the prior honorable period of obligated service.¹

A discharge found by VA to have been issued under dishonorable conditions does not, in and of itself, bar an individual from receiving VA benefits based on an earlier period of service that terminated under conditions other than dishonorable. VA long ago adopted an administrative interpretation that a discharge under dishonorable conditions from one period of service does not constitute a bar to VA benefits if there was another period of qualifying service upon which a claim could be predicated. This interpretation is currently reflected in the language of 38 C.F.R. § 3.12(a), which provides, in part, that "if the former service member did not die in service, pension, compensation, or dependency and indemnity compensation is not payable unless *the period of service on which the claim is based* was terminated by discharge or release “under conditions other than dishonorable” [emphasis added].²

The definition of a veteran established by the Servicemen's Readjustment Act of 1944 (Pub. L. No. 78-346, ch 268, 58 Stat. 284, 301 [1944]) has remained essentially unchanged since its enactment. Both the language used in the definition and its legislative history clearly show congressional intent that VA

¹ VA Office of General Counsel, *Precedent Opinion 61-91*, 3.

² *Ibid.*, 2.

determine whether a discharge, on the basis of the overall conditions of service, was issued under conditions other than dishonorable in a case where the discharge or release was given for conduct that was less than honorable, but where the military did not elect to terminate service through a dishonorable discharge.

Discharges in this category include undesirable, other than honorable, and bad conduct discharges. Releases in this category include uncharacterized separations because of void enlistment or induction or being dropped from the rolls. The latter two uncharacterized separations are considered the equivalent of discharges issued under other than honorable conditions. Such discharges or releases are considered to have been issued under dishonorable conditions if they were issued because of offenses, such as acceptance of an undesirable discharge to escape trial by general court-martial, mutiny or spying, or an offense involving moral turpitude. This includes, generally, conviction of a felony.³

VA is authorized to provide health care and related benefits under chapter 17 of title 38, United States Code, for a disability incurred or aggravated in line of duty by a person who received an other-than-honorable discharge. These benefits are not available to a person who either received a bad conduct discharge or a discharge was issued under one of the statutory bars listed in 38 C.F.R. 3.12(c) (38 C.F.R. 3.360 [2006]).

Commissioned or warrant officers may be held to a different standard. In their case, the entire period of active duty is considered as one period of active service, and entitlement is determined by the character of the final termination of such period of active service (38 C.F.R. 3.13[b] [2006]). The exception to this rule is that a person will be considered to have been unconditionally discharged or released from active duty when the following conditions have been met:

- (1) The person served in the active military, naval, or air service for the period of time the person was obligated to serve at the time of entry into service;
- (2) The person was not discharged or released from such service at the time of completing that period of obligation due to an intervening enlistment or reenlistment; and
- (3) The person would have been eligible for a discharge or release under conditions other than dishonorable at that time except for the intervening enlistment or reenlistment (38 C.F.R. 3.13[c] [2006]).

³ For a full listing of discharges and releases in this category, please refer to 38 C.F.R. 3.12(d).

The last types of cases to consider are those in which an individual receives an uncharacterized separation (38 C.F.R. 3.12[k] [2006]). In cases in which enlisted personnel are administratively separated from service on the basis of proceedings initiated on or after October 1, 1982, the separation may be classified as one of the following three categories of administrative separation: entry-level separation, void enlistment or induction, and dropped from the rolls. Entry-level separations are considered to have been issued under other than dishonorable conditions. Void enlistment or induction separations and dropped from the rolls separations require VA to make an administrative determination as to whether or not the separation was issued under conditions other than dishonorable.

Table 5.1 illustrates the numbers and percentages of service members who received each type of discharge between October 2000 and September 2005.

Table 5.1 Types of Discharges, October 2000–September 2005

Type	Percentage of separating service members (%)	No. of separating service members
Honorable	69.2	654,350
General discharges (under honorable conditions)	5.6	53,181
Bad conduct	0.9	8,190
Under other than honorable conditions	5.8	55,111
Dishonorable	0.0	513
Uncharacterized	12.6	118,918
Unknown/not applicable	5.9	55,333
TOTAL	100	945,596

NOTE: LtCol. Applegate further clarified the number and types of discharges. She wrote that these numbers reflected only active duty, but she cautioned that there might be a small number of cases where Guard or Reserve members were on active duty when they were discharged.

SOURCE: Applegate. *Discharge Information*, e-mail to Steve Riddle on June 20, 2007.

VA provided the following information to aid the Commission during its study of types of discharges:⁴

- 3,048,116 veterans currently receive disability compensation or non-service-connected pension. Of these:
 - 3,414 veterans are noted as having been determined by VA as having honorable discharges for VA purposes. This is a decision made by VA after discharge.
 - 4,565 veterans are noted as having been determined by VA as having dishonorable discharges for VA purposes.⁵
- 46,476,819 veterans have records in the VA Beneficiary Identification and Records Locator Subsystem (BIRLS) (almost half of these veterans are deceased.) Of these:
 - 28,459 veterans are noted as having been determined by VA as having honorable discharges for VA purposes.
 - 100,781 veterans are noted as having been determined by VA as having dishonorable discharges for VA purposes.
 - 117,283 veterans are noted as having a separation reason code of “administrative decision made.”
- Note that these are unique veterans; veterans may have had multiple administrative decisions made for different periods of service.

The Bradley Commission proposed two recommendations regarding discharge requirements for veterans’ benefits. The first recommendation was that an undesirable discharge for an enlisted man and a discharge under other than honorable conditions for an officer should render a claimant ineligible for benefits based upon the period of service from which he or she was so discharged, also stating, however, that health care should be provided by VA if the claimant suffered a service-connected disability unrelated to the reason for discharge. Secondly, the Bradley Commission recommended that anyone receiving a bad conduct discharge, whether imposed by a general or special court-martial, should be rendered ineligible for VA benefits based upon the period of service from which so discharged.⁶

⁴ Office of Performance Analysis & Integrity (OPA&I), data request 06-176.

VA has clarified that it was during a previous period of honorable service that these veterans incurred an injury or contracted an illness that caused their disability.

President’s Commission, *Findings and Recommendations*, 393–397.

⁵ VA has clarified that it was during a previous period of honorable service that these veterans incurred an injury or contracted an illness that caused their disability.

⁶ President’s Commission, *Findings and Recommendations*, 393–397.

I.1.B Findings

Basic eligibility for most benefits administered by VA is contingent on an individual being characterized as a veteran. The definition of “veteran” is a person who served in the active military service and who was discharged “under conditions other than dishonorable.”

Congress adopted this statutory definition in 1944 to establish a comprehensive standard governing basic eligibility for veterans’ benefits based upon the character of an individual’s discharge or release from active military service. On the basis of the legislative history of that definition, it is clear that Congress intended to liberalize the then existing requirement of a discharge under honorable conditions and correct what Congress viewed as an overly strict standard that unjustly prevented many who served faithfully, but were separated for relatively minor offenses, from receiving veterans’ benefits. At the same time, Congress recognized that a dishonorable discharge could only be given pursuant to a general court-martial and that some individuals were released without the formality of such a proceeding. In such cases, Congress was adamant that veterans’ benefits should not be available.

Congress adopted the phrase “under conditions other than dishonorable” to accomplish its goals of liberalizing the standard for establishing basic eligibility for veterans’ benefits and, at the same time, barring benefits to individuals separated for serious offenses. By adopting this phrase, Congress authorized VA to accept characterization of a discharge or release by one of the uniformed services to the extent that the discharge or release is issued under clearly honorable or dishonorable conditions. The phrase also gave VA the authority and discretion to make its own character-of-discharge determinations for VA benefit purposes in cases where the discharge or release was neither specifically honorable nor dishonorable.

The present law, as amended in 1977, allows individuals who were discharged under dishonorable conditions, or conditions otherwise precluding veteran status, to receive VA benefits based upon a separate period of service. The Commission does not agree with this policy.

The Commission believes that service members who receive bad conduct or dishonorable discharges should be barred from receiving VA benefits. These types of discharges are the result of conduct that is abhorred by the United States military, and often times includes criminal acts. From 2000 to 2005 only approximately 1 percent of all military discharges came under these two headings as shown above in Table 5.1. Therefore the Commission recommends the following:

Recommendation 5.1

Congress should change the character-of-discharge standard to require that when an individual is discharged from his or her last period of active service with a bad conduct or dishonorable discharge, it bars all benefits.

I.2 Line of Duty

I.2.A Issue

“Line of duty” is a fundamental principle in veterans’ disability benefits because, by law, a causal relationship between military service and death or disability is established only when the disability or death is incurred or aggravated *in the line of duty* (38 CFR 3.301 [2006]). The definition of “line of duty” for the U.S. military has been a source of debate for years. Interpretations of the meaning can be traced at least as far back as the late 18th century, when the debate focused on what constituted a service member’s duty status. Currently, a service member is considered to be in the line of duty all day every day, including when on leave. The foundation for this definition is our nation’s sense of moral obligation to citizens when they are called to serve their country. This definition entitles service members to VA benefits and services for disabilities resulting from injuries incurred or diseases contracted while in active military service, whether on active duty or authorized leave, unless the injury or disease arose from the individual’s willful misconduct or abuse of alcohol or drugs. Critics argue, however, that military personnel should be compensated for injuries or diseases that occur only as a direct result of the performance of military duties, implying that the line of duty definition should not extend to all times and places.

The General Accounting Office (GAO)⁷ suggested in 1989 that Congress might wish to reconsider limiting compensation to injuries or diseases that occur while performing actual military duties. The report concluded that, in 1986, 19 percent of veterans had diseases unrelated to service and were compensated approximately \$1.7 billion as a result.⁸ GAO suggested that VA should grant service-connection compensation only for injuries and diseases directly attributable to military service.

In March 2003, the Congressional Budget Office (CBO) reported that 290,000 veterans received approximately \$970 million for the disabilities that GAO found in 1989 were not caused as a direct result of military service.⁹ CBO found potential savings of approximately \$1 billion by restricting the criteria for granting

⁷ Prior to July 7, 2004 the Government Accountability Office was the General Accounting Office.

⁸ Government Accountability Office (GAO), *Disabilities Unrelated to Military Service*, 28.

⁹ Congressional Budget Office, *Budget Options March 2003*.

service connection to compensate veterans. “Opponents of this option,” CBO observed, “could hold the view that veterans' compensation benefits are payments that the Federal Government owes to veterans who became disabled in any way during their service in the armed forces.”¹⁰

The United Kingdom, Australia, and Canada have narrower definitions of “line of duty” than does the United States. Those other governments offer compensation to veterans for illnesses or injuries that occurred at any time in a war zone, but offer compensation only in connection with activities that are directly related to military service when troops are not engaged in war or are performing military training exercises. However, those countries offer other benefits to all citizens, such as universal health care, that are not available in the United States.

Likewise, the benefit plans of civilian public safety officers (PSOs), including law enforcement officers and firefighters, have narrower definitions of “line of duty” than the U.S. military has. Usually the injury or illness must occur during working hours when the PSO is performing assigned duties or engaging in an activity that is reasonably associated with employment.¹¹

The Commission also reviewed VA disability compensation practices during the period of 1933 to 1972, when veterans who served during peacetime were paid disability compensation at rates lower than those of veterans who served during wartime. From 1933 to 1939, the peacetime rate was 50 percent of the wartime rate. From 1939 to 1948, the peacetime rate was 75 percent of the wartime rate. And from 1948 to 1972, the peacetime rate was 80 percent of the wartime rate. VA notified Congress by letter in 1965 that it believed veterans suffered the same loss of earnings for identical disabilities and that it could no longer justify continuing to pay disability compensation at different rates depending on whether the illness or injury occurred during peacetime or wartime.

It is also relevant to consider whether the line of duty should encompass the same period as when service members must follow the Uniform Code of Military Justice (UCMJ), the comprehensive set of principles that underpin U.S. military law. According to 47 U.S.C. § 802 (2)(c), all service members are “subject to this chapter until such person’s active service has been terminated in accordance with law or regulations promulgated by the Secretary concerned.” Not only are all military personnel held to this code, but according to 47 U.S.C. § 805 (5), they are subject to the UCMJ “in all places.” In other words, the U.S. military is held to the requirements of the UCMJ at all times and in all locations, including while on leave. A question that then arises is whether any illness or injury that occurs

¹⁰ Ibid.

¹¹ GAO, *Disability Benefits*, 11.

while the service member is subject to UCMJ—that is, at all times and in all places—should be viewed as connected to service. If so, then the line of duty includes all times and places that the service member is on active duty or authorized leave.

Finally, the Commission noted that it is standard practice in American industry to provide health insurance for employees. If periods other than direct duty were excluded from the line of duty, then DoD would need to offer service members a health insurance program that provides coverage for the excluded periods.

I.2.B Findings

The Commission agrees with the arguments made in favor of the current definition of “line of duty.” Since the 18th century, the United States has supported its citizens who have answered the call to defend their country. As clearly stated in the UCMJ, active duty is considered to be 24 hours a day, 7 days a week. Around the clock, service members are on call to perform high-risk tasks that may cause traumatic injuries and are subjected to dangerous stressors and exposures. Injuries incurred and diseases contracted while a service member is in active military, naval, or air service, whether on active duty or authorized leave, are considered to be in the line of duty unless they are due to the service member’s willful misconduct or abuse of alcohol or drugs. Under this definition, VA services and benefits, including compensation, hospital care, and medical services, are available for a disability resulting from injury suffered or disease contracted in the line of duty in the active military, naval, or air service, whether on active duty or authorized leave, and not due to their own willful misconduct or abuse of alcohol or drugs. Therefore, the Commission recommends the following:

Recommendation 5.2

Maintain the present definition of line of duty: that service members are on duty 24 hours a day, 7 days a week.

Previous attempts to award benefits at different rates or not at all unless disabilities were incurred during wartime periods or in combat theaters or operations have been found to be unjustified and unfair.

Recommendation 5.3

Benefits should be awarded at the same level according to the severity of the disability, regardless of whether the injury was incurred or disease was contracted during combat or training, wartime or peacetime.

I.3 Reasonable Doubt

I.3.A Issue

Regardless of whether it is called the "reasonable doubt" standard or the "benefit of the doubt" standard, the standard of proof a VA claimant is required to meet to establish entitlement to veterans' benefits is among the most liberal used in any adjudicatory proceeding. In *Gilbert v. Derwinski*, the Court of Veterans Appeals wrote:

This unique standard of proof is in keeping with the high esteem in which our Nation holds those who have served in the armed services. It is in recognition of our debt to our veterans that society has through legislation taken upon itself the risk of error when, in determining whether a veteran is entitled to benefits, there is an "approximate balance of positive and negative evidence." By tradition and by statute, the benefit of the doubt belongs to the veteran (*Gilbert v. Derwinski*, 1 Vet. App. 49, 54 [U.S. Court of Veterans' Appeals 1990]).

Discussions about the reasonable doubt standard occurred as early as 1855, when Attorney General Cushing argued, in an opinion concerning the definition of "line of duty," that "it would be reasonable to presume in favor of the veteran" in cases where a reasonable doubt existed (7 Op. Att'y Gen. 149, 165-166 [1855]). The first rating tables and schedules were promulgated after World War I, and one of the earliest of these tables specified that cases in which "a question of doubt" arose should be resolved in the veteran's favor. Subsequent rating tables and schedules continued to refine and promulgate the reasonable doubt standard. Then, in 1933, Congress enacted the Economy Act, which included the first legislative requirement of the reasonable doubt standard (Pub. L. No. 73-2, 48 § 8 [1933]).

In 1941, Congress promulgated a law similar to the current standard of reasonable doubt, directing VA to "resolve every reasonable doubt in favor of [the] veteran" (Pub. L. No. 77-361, ch. 603, 55 § 847 [1941]). The reasonable doubt standard remained unchanged until 1985, when Congress clarified the language of the law by defining reasonable doubt as "[doubt] which exists because of an approximate balance between positive and negative evidence" (38 U.S.C. 1154 [2006]). Congress last revised the reasonable doubt standard in 2000, when it passed the Veterans Claims Assistance Act. That act edited some wording in the reasonable doubt section in the U.S. Code, but those edits "had no substantive impact" on the standard (38 C.F.R. 3.102 [2006]).

The reasonable doubt standard is meant to ensure that decisions on claims result in the fairest possible outcome for the veteran. In cases where the

evidence does not clearly prove or disprove service connection, the reasonable doubt standard is applied and the case is decided in favor of the claimant.

To date, there has been little debate over the use of the reasonable doubt standard.

I.3.B Findings

The reasonable doubt standard has been a consistent fixture of the VA claims process since the 1850s. There has been little criticism of the standard.

Recommendation 5.4

Maintain the current reasonable doubt standard.

I.4 Age as a Factor

I.4.A Issue

Currently, age is not a factor in evaluating service connection, and there is no statutory history on age as a factor. If a disability is deemed to have been caused by service, all subsequent manifestations that develop are also service connected. As provided by 38 C.F.R. 3.303(b) [2006], "subsequent manifestations of the same chronic disease at any later date, however remote, are service connected, unless clearly attributable to intercurrent causes." The worsening of a disability over time, as opposed to acceleration by postservice injuries or superimposed diseases, is not an intercurrent cause. Since service-connected disabilities, like other degenerative and progressive diseases, worsen as part of the natural aging process, the Commission asked if the age of the veteran should be a factor when he or she is applying for compensation. For example, should a 45-year-old military retiree who gradually develops arthritis over many years be compensated for that disease, and should such a case differ from that of a 22-year-old veteran who claims arthritis due to a traumatic injury? The Commission also investigated whether a veteran should be compensated more for a condition that impairs the individual more severely because of his or her age.

Among the 2.7 million veterans who received VA compensation for a service-connected disability in fiscal year 2006, 162,805 veterans were receiving that compensation for the first time.¹² Tables 5.2 and 5.3 illustrate the age distribution of those two groups of veterans.

¹² Cohen, Email message to Commission staff.

Table 5.2 Initial Disability Awardees Distribution by Age for 2006

Age Group	Percentage (%)	Actual Numbers
< 35 years	20.4	40,989
36–55 years	34.1	54,187
56–75 years	36.6	55,039
75+ years	9.0	12,590
Total	100	162,805

SOURCE: Cohen, E-mail message to Commission staff.

Table 5.3 All Veterans Receiving Compensation by Age for 2006

Age Group	Percentage (%)	Actual Numbers
< 35 years	7.8	213,566
36–55 years	30.6	833,346
56–75 years	42.4	1,156,703
75+ years	19.2	522,209
Total	100	2,725,824

SOURCE::Cohen, E-mail message to Commission staff.

Some 61.6 percent of the total population of service-connected veterans in 2006 was 56 years of age and older, but only 41.5 percent of those first receiving compensation were that age. By contrast, only 7.8 percent of all service-connected veterans in 2006 were 35 years of age or younger, but 25.2 percent of those first receiving compensation in 2006 were that age.

In its July 1984 report *Caring for the Older Veteran*, VA studied how it would face the challenges associated with an increasingly older population of veterans. VA reported that aging “increases the susceptibility to certain conditions, particularly those that result from degenerative changes in the body’s tissue and organ systems.”¹³ For example, the elderly are more at risk for “cardiovascular diseases, diseases of the bones and joints, and sensory impairment.”¹⁴ Furthermore, there are diseases that may be common to other age cohorts that

¹³ VA, *Caring for the Older Veteran*, 3.

¹⁴ Ibid.

“act differently when they occur in an older person” or “may occur silently in older persons.”¹⁵

In today’s world, increasingly more elderly individuals pursue independent, active lifestyles. VA contended that “older individuals prefer to retain their independence to the maximum extent possible, and maintenance of such independence is widely accepted as the primary goal of programs and services for the elderly.”¹⁶ VA has appreciated the need to give elderly veterans levels of care and benefits that help maximize their ability to function and attain life goals.

Although there was a steady decline in labor force participation by Americans (including veterans)¹⁷ ages 65 and older from the 1960s to the 1980s, that trend reversed in the 1990s.¹⁸ By 2003, 33 percent of men and 23 percent of women ages 65 and older were working.¹⁹ In addition, the rates of chronic disability among the elderly declined by 5 percent since 1987.²⁰ According to the Federal Interagency Forum on Aging-Related Statistics, “functioning in later years may be diminished if illness, chronic disease, or injury limits physical and/or mental abilities. Changes in disability rates have important implications for work and retirement policies, health and long-term care needs and the social well-being of the older population.”²¹

According to VA, trends among veterans ages 65 and older have generally been consistent with those of the general population.²² This cohort of veterans generally suffers from the same conditions as its peers and experiences about the same rate of unemployment. However, older veterans are more likely to have health insurance than their peers in the general population.²³

Veterans’ disability percentage ratings, when viewed by age, do not vary significantly for individuals above and below 66 years of age. The most frequent evaluation is at the 10 percent level.²⁴ Regardless of age, veterans may need to access VA benefits and programs created to enhance their quality of life and help them maintain their independence and productivity.

¹⁵ Ibid.

¹⁶ Ibid., 3.

¹⁷ Ibid., 74, 109.

¹⁸ Forum on Aging-Related Statistics, *Older Americans 2004*, 18–19.

¹⁹ Ibid.

²⁰ Ibid., 28.

²¹ Ibid., 28.

²² Dunne, *Older Veterans Update*.

²³ Ibid.

²⁴ Ibid.

Rather than allowing age to be a factor in disability ratings, the 1956 Bradley Commission decided that it was more important to focus “on helping those who need assistance most, and helping them more adequately.”²⁵ The Bradley Commission’s reasoning regarding age as a factor for non-service-connected veterans’ pensions is applicable to this Commission’s investigation of age as a factor for service-connected disability compensation. The Bradley Commission determined that age is an inadequate surrogate for measuring ability. The commission also noted that 65 is a somewhat arbitrary age for retirement. The concept of “age 65 as retirement age goes back to the mid-1930s, when depressed labor market conditions made it desirable to encourage people to retire early.”²⁶ A recent study showed that 65-year-olds are able to successfully gain employment.²⁷ The Bradley Commission determined that despite the common belief that 65 is retirement age, individuals who are fit to work should still be able to do so.

Under the “new wars” legislation investigated by the Bradley Commission, a veteran could qualify for a pension if his or her level of disability was determined to be permanent and total. However, as a veteran aged, the level of disability required to qualify for the same pension was reduced. For example:

A combined disability evaluation of 70 percent or even 60 percent, if arising from one single cause, is considered sufficient at any age to meet this definition. For veterans aged 55 to 59 and 60 to 64, the 70 percent is reduced to 60 and 50 percent, respectively, from any or all causes. At age 65, and thereafter, a 10 percent impairment from disability is deemed sufficient.²⁸

In other words, as a veteran aged, it became easier for him or her to receive a pension because the minimum requirements were lower.

The Bradley Commission found that “undue reduction of the disability requirement by reason of age alone tends to undermine the system by opening it to those whose needs are less urgent.”²⁹ Therefore, the Bradley Commission suggested that “a minimum requirement of more substantial disability at the higher ages will assure that veterans of any age, who are genuinely unemployable because of disablement, can continue to rely on the pension program in case of need.”³⁰

²⁵ President’s Commission, *Findings and Recommendations*, 387.

²⁶ *Ibid.*, 386.

²⁷ Forum on Aging-Related Statistics, *Older Americans 2004*, 18–19.

²⁸ President’s Commission, *Findings and Recommendations*, 386.

²⁹ *Ibid.*, 387.

³⁰ *Ibid.*, 387.

The Bradley Commission reached this conclusion because having a minimum disability requirement for unemployability will “preclude the gradual transformation of this program into one providing pensions to practically all veterans attaining age 65.”³¹ In the views of the Bradley Commission, it was more important to devote resources to veterans with the greatest needs than to veterans of a certain age. A veteran should not be prevented from receiving needed pension, nor should that veteran receive pension based on age alone.

In 1989, GAO reported on the *Law Allows Compensation for Disabilities Unrelated to Military Service* and found that “there are 71 diagnoses that their [GAO’s] physicians concluded were neither caused nor aggravated by military service.”³² The most common of these diseases were diabetes, chronic obstructive pulmonary disease, appendicitis, osteoarthritis, cerebral vascular accidents (stroke), arteriosclerotic heart disease, multiple sclerosis, Hodgkin’s disease, hemorrhoids, benign prostatic hypertrophy, uterine fibroids, Crohn’s disease, and schizophrenia.³³ GAO physicians did not conclude that these conditions never would be caused or aggravated by military service, but in the cases reviewed, they did not find a direct correlation.³⁴ For some of these diseases, GAO concluded that the onset is age related and that the disease can be chronic and progressive.

In March 2003, the Congressional Budget Office (CBO), relying on the diseases identified in the 1989 GAO study, reported that about 290,000 veterans received approximately \$970 million in 2002 for disabilities that were generally neither caused nor aggravated by military service. The diseases listed by CBO were osteoarthritis, chronic obstructive pulmonary disease, arteriosclerotic heart disease, Crohn’s disease, hemorrhoids, uterine fibroids, and multiple sclerosis. (This excluded diabetes because VA had subsequently granted service connection on a presumptive basis due to Agent Orange exposure.) Ending “new compensation benefits for veterans with only those seven diseases would save...\$449 million over the 2004–2008 period.”³⁵ Furthermore, CBO stated that the elimination of compensation “for veterans whose compensable disabilities are also unrelated to military service would create significantly larger savings.”³⁶

Although CBO found potential savings by restricting the criteria for granting service connection to compensate veterans, it observed that “opponents of this option could hold the view that veterans’ compensation benefits are payments that the Federal Government owes to veterans who became disabled in any way

³¹ Ibid.

³² GAO, *Law Allows Compensation*.

³³ Ibid.

³⁴ Ibid.

³⁵ Congressional Budget Office, *Budget Options*.

³⁶ Ibid.

during their service in the Armed Forces.”³⁷ Because an individual served in the military, CBO suggested that he or she should be compensated for an injury, a disease, or both, regardless of how it happened, regardless of direct connection to military combat. This type of reasoning is applicable when determining if age should be a factor for service-connected compensation as well.

Although it may be appropriate to consider age as a factor when determining a VA pension or Social Security benefits, some argue that it would be inappropriate to consider age when determining entitlement to veterans’ compensation for two reasons: first, the purpose of such compensation is to relieve aging veterans of distress from disability or destitution; and second, the purpose of compensation is to make up for the effects of service-connected disability and thus should not be tied to factors extraneous to the character of the disability, such as age.³⁸

I.4.B Findings

Limited information is available to address the issue of age as a factor in evaluating a claim for disability. GAO, CBO, and VA’s *Caring for the Older Veteran Report* have noted that some diseases are more likely than not to arise from normal life experiences and aging, but can reoccur during or be aggravated by military service. Some of these conditions may have a delayed or gradual onset and therefore may be diagnosed years after discharge from military service. In such cases, veterans may first apply for benefits years or even decades after military service. Currently, each application for benefits by any veteran is adjudicated on its own merit using available medical evidence.

When a veteran has established that a disability was either incurred during or aggravated by military service, and service connection has been granted for that disability, the next decision is to assign a level of severity in accordance with the *VA Schedule for Rating Disabilities*. Age, by VA regulation, is currently not considered in evaluating service-connected disability.

Although studies by GAO and CBO have recognized the cost factors associated with disabilities not thought to be caused by military service, neither organization has recommended changes to the current regulations. During its discussions, the Commission supported the current practice that age should not be a factor in entitlement to service-connected compensation. Additionally, there should be no difference in entitlement to compensation regardless of the age of the veteran or when the veteran decided to first file a claim.

³⁷ Ibid.

³⁸ Disabled American Veterans, testimony.

In an earnings analysis directed by the Commission, the CNA Corporation (CNAC) found that those who enter the system at younger ages do not achieve parity with their non-service-connected peers, while those entering at older ages achieve greater than parity because of few working years remaining. The Commission decided to address age at entry into the system separately from the use of age as a factor in evaluating entitlement to service connection or evaluation of the degree of severity of a service-connected disability. Therefore, the Commission recommends the following:

Recommendation 5.5

Age should not be a factor for rating service connection or severity of disability, but may be a consideration in setting compensation rates.

I.5 Time Limit to File

I.5.A Issue

Currently, there is no time limit for filing an original claim for service connection. The War Risk Insurance Act of 1917, which replaced the General Pension Act of 1862, provided service-connected benefits to veterans and survivors and eliminated rank as a factor in determining the rate of compensation. There were two provisions of this act that were significant for the time limit in which to file claims for service connection. The first limitation, found in section 306 of the act, stated that the disability or death had to have occurred prior to or within 1 year after discharge or resignation from service. The second limitation, in section 309 of the act, placed a 5-year time limit upon filing compensation claims. Therefore, no compensation was available for disabilities that occurred more than 1 year after separation from duty, unless it could be demonstrated that the disability existed within that time period. Furthermore, the initial claim for compensation had to be submitted within 5 years of separation from duty. These two limitations were liberalized to some degree over the years, but remained in effect until their repeal in the World War Veterans' Act of 1930 (Pub. L. No. 71-522, 46 Stat. 991, 1000 [1930]).

The Veterans' Claims Adjudication Commission (VCAC), in their 1996 *Report to Congress*, suggested that establishing a time limit for filing claims for disability compensation warranted consideration. VCAC studied frequency of claims for disability compensation received during FY 1995, and, of the 299 claims reviewed in the study, 63 percent of original claims for disability compensation were filed within 1 year of separation. However, a significant number, almost 22 percent, were filed more than 20 years after separation.³⁹ Thus, while it

³⁹ Veterans' Claims Adjudication Commission (VCAC), *Report*, 70.

appears that most current claims would fall within a likely time limit, it is probable that a sizable number of veterans would indeed be excluded from compensation by such a limit.

VCAC recognized that traditionally, veterans have had an unlimited period of time in which to file a claim, but noted that:

This generous filing privilege may be regarded as an advantage by veterans, but it also has certain disadvantages for them, [because] veterans' needs change over time and it is possible that the advantage of an open-ended filing period has changed with time as well.⁴⁰

VCAC therefore went on to outline the most common arguments on both sides of the debate over imposing a time limit on filing claims, beginning with the arguments in favor of such a limit:

A time limit for filing an initial disability compensation claim would encourage veterans to file relatively early—at the very time when they are most likely to be able to establish entitlement. Documentation is most readily available during the first few years following service. Service “buddies” are easier to contact for supporting evidence or testimony. Intervening medical problems, which make it more difficult to meet the legal requirements for entitlement, are less likely to occur. Postponing filing only increases the chances that evidence will be lost, destroyed, or otherwise degraded.⁴¹

Thus, it is argued that imposing a limited period in which to file a claim, and appropriately informing veterans of its existence and significance, could raise awareness that the legal requirements for receiving disability compensation are easier to fulfill the sooner the claim is filed. This increased awareness could influence veterans to improve the quality of their benefit claims beyond the extent to which simply submitting claims in a timely manner would improve them. Furthermore, an environment of timely filed claims would lead to less time-consuming claims processing, because VA would not have to expend scarce resources in unproductive efforts to locate or reproduce decades-old or lost evidence. Resources could be concentrated on processing timely filed claims, because *all* claims would be filed in a reasonably timely manner. It may be for this reason that most other governmental and private disability compensation systems impose a time limit on filing initial claims. Many also point out that “a

⁴⁰ *Ibid.*, 347.

⁴¹ VCAC, *Report*, 347.

time limit on initial claims would *not* prohibit or inhibit claims for increased evaluation."⁴²

Some also argue that there should be no reason to maintain a lifelong filing period:

Comprehensive services currently available *prior* to separation suggest any need for lifelong opportunity to claim disability compensation is decreased. Although unquantified, the transition services provided to 1.4 million separating service members worldwide by VA, DoD, and DOL from FY 1992 through FY 1995, increased the percentage of discharges who file claims for benefits. In addition, VA/Army's separation examination tests are evaluating several methods for conducting examinations for separating and retiring service members who intend to file a disability claim with VA. Carrying this concept to its logical extreme, VA and DoD could cooperatively track veterans' health on *entry* into service. This could lead to a paperless benefits delivery system in which veterans would not need to apply for benefits. On discharge, VA would have all information needed to pay appropriate benefits without any action on the veteran's part.⁴³

It should be noted that current law does require a veteran to submit a specific claim in order for compensation to be paid.⁴⁴ In addition, comprehensive services are not universally available at this time. For example, the Benefits Delivery at Discharge program is limited to approximately 140 separation sites.⁴⁵ Service persons at remote and small sites, and those separated while at sea, do not have as much access to these services.⁴⁶

Concerning the time limit issue, the Under Secretary for Benefits for the Department of Veterans Affairs wrote to this Commission in support of examining the arguments in favor of a time limit:

Today, there is no time limit for a veteran to submit an initial claim for disability compensation. He or she can be 18 or 85, have been on active duty for 6 months or 50 years, and can submit the claim immediately upon leaving the service or decades later...In today's VA, with strong emphasis in veterans' outreach, it should not be unreasonable to have a limit, at least for the time frame allowed for the initial filing of a claim. Further, the availability, to an extent not

⁴² Ibid., 348.

⁴³ Ibid.

⁴⁴ Memo from Acting VA General Counsel, January 12, 2007.

⁴⁵ VA Fiscal Year 2007 Budget Request, Statement of Daniel L. Cooper.

⁴⁶ VA Compensation and Pension Service, Technical Comments.

present earlier, of the Benefits Delivery at Discharge (BDD) Program might be a consideration for some delimiting time for an original claim.⁴⁷

Against this support of a time limit, there are a number of arguments in favor of the current system. The first concern for those who oppose a time limit is that some veterans may not become aware that they must file an initial disability compensation claim within a certain period of time. While there could be exceptions for allowing veterans who were physically or mentally unable to file, it would be difficult to provide exceptions on the basis of unawareness. Between the lack of information and knowledge regarding eligibility, and the “red tape” associated with filing a claim, even with the current unlimited filing period, it is already possible for veterans to “fall through the cracks” of the current VA system. These obstacles may then become even greater if a time limit is imposed. If veterans today are sometimes unaware of the compensation and benefits available to them, it is likely that such veterans would also be unaware of any time limits associated with those veterans, causing them to lose the opportunity to avail themselves of the compensation due to them.

Furthermore, in spite of best efforts to inform veterans, it is possible that some veterans may not realize that a condition, which is not bothersome or disabling, should be evaluated anyway. Veterans may, believing themselves not entitled to compensation payments, choose not to apply within the time limit. If the condition then worsened after the time limit had expired, the veteran would have inadvertently forfeited his entitlement to compensation.⁴⁸

Based on these arguments, many claim that an unlimited time to file is a right that protects veterans’ vital interests. Veterans should have an open process for claiming compensation, and they should not be pressured into filing claims under what amounts to a “use it or lose it” ultimatum. And, because VCAC found no evidence of large numbers of claims filed late to justify any delimiting periods, there seems to be no imminent administrative need to impose a time limit. Without such a need, and considering the negative effects a time limit could impose on the compensation system, it would be inappropriate to impose a time limit to file an initial claim for compensation.⁴⁹

In testimony before the House Veterans’ Affairs Committee in May 1997 on the report of the Veterans’ Claims Adjudication Commission, the DAV opposed the imposition of a time limit for filing compensation claims. In supporting the

⁴⁷ Cooper, Daniel L., Under Secretary for Benefits for the Department of Veterans Affairs, before the Veterans’ Disability Benefits Commission, Washington, D.C., July 22, 2005.

⁴⁸ VCAC, *Report*, 348.

⁴⁹ *Ibid.*, 376.

unlimited time limit in which to file an original claim for service connection, DAV noted:

The disadvantages of time limits for filing claims far outweigh any advantages. Currently, conditions such as posttraumatic stress disorder (PTSD), asbestosis, and radiogenic diseases can be service connected without regard to how long after service they are first shown. This is because of their characteristically delayed clinical manifestations or latency periods... Sometimes evidence first discovered years after service can support a claim for service connection. In other instances, proof is unavailable for years because of government secrecy... The law provides that some conditions, such as those of former prisoners of war, will be presumed service connected no matter how long after service they first manifest. The system is designed to avoid defeating meritorious claims by mere technicalities and artificial constraints.⁵⁰

I.5.B Findings

There is no time limit for veterans and their dependents to file a claim for service-connected disability and death benefits, and this standard has remained unchanged for over 75 years. Although the Commission found that the arguments in favor of imposing a time limit were unconvincing, the issue did raise important concerns regarding the degree to which veterans are educated about the benefits available to them. To date, there have been significant outreach efforts by VA and DoD to educate veterans as to their benefit entitlements, along with significant improvements in recordkeeping and documentation of medical records by VA and DoD. In keeping with these developments, the Commission discussed the merits of mandating that a benefits briefing be provided to all separating military personnel. Therefore the Commission recommends the following:

Recommendation 5.6

Maintain the current standard of an unlimited time limit for filing an original claim for service connection.

Recommendation 5.7

DoD should require a mandatory benefits briefing to all separating military personnel, including Reserve and National Guard components, prior to discharge from service.

⁵⁰ Surratt, testimony before House Veterans' Affairs Committee.

II Presumption Decisions

II.1 Overview

This section discusses issues regarding presumptive service connection. An increasing proportion of benefits is paid through a presumptive decision-making process. Therefore, this Commission sought the expert advice of the Institute of Medicine (IOM) regarding the process by which presumptions of service connection are established.

As the VA stated in its “Analysis of Presumptions of Service Connection” (Dec. 1993, submitted to Senate Veterans Affairs Committee):

Generally, a legal presumption is a procedural device that shifts the burden of proof by attaching certain consequences to the establishment of certain basic evidentiary facts. When the party invoking a presumption establishes the basic fact(s) giving rise to the presumption, the burden of proof shifts to the other party to prove nonexistence of the presumed fact. A presumption, as used in the law of evidence, is a direction that if fact A (e.g., manifestation within the specified period of a disease for which a presumption of service connection is available) is established, then fact B (service connection) may be taken as established, even where there is no specific evidence proving fact B (i.e., no medical evidence of a connection between the veteran’s disease and the veteran’s military service).⁵¹

Since the early part of the 20th century, the Congress and VA have used the concept of presumptions to facilitate the decision process for VA disability compensation. The first legislation explicitly providing a presumption of service connection to mitigate the difficulty of proving a connection between military service and development of a disability was the Act of August 9, 1921 (42 Stat. 147, ch. 57). This act established the Veterans’ Bureau and, in section 300 of the War Risk Insurance Act, presumptions of service connection for active pulmonary tuberculosis and neuropsychiatric disease were added. This bill provided that the specified diseases developing to a degree of disability of more than 10 percent within 2 years following separation from active military service would be considered to have had their origin in service or to have been aggravated by service.⁵²

⁵¹ VA, “Analysis of Presumptions.”

⁵² *Ibid.*, 7, 8.

This initial presumptive legislation was intended to overcome difficulties being observed in fixing a time of onset for these diseases. The belief of the author, Senator Walsh, was that “the great number of ex-servicemembers afflicted with tuberculosis and nervous disorders...could not be expected to be so afflicted naturally.”

After the first legislation on presumptions, there were periodic additions and changes enacted through the 1950s. Legislation in the 1970s through the 1990s greatly expanded the impact of presumptions. This era saw increasing concerns—and resulting legislation—about disabilities related to ex-prisoners of war, exposure to ionizing radiation, and service in Vietnam. Because of the volume of veterans affected by these phenomena, the impact of presumption decisions increased dramatically.

An extreme example of the impact of presumptions is shown by a brief look at diabetes and the endocrine body system. In 2001, the VA Disability Compensation Program was paying 68,040 veterans for disabilities in the endocrine system, including diabetes. In 2001, the VA established presumptive service connection for type 2 diabetes based on herbicide exposure in Vietnam veterans. By 2005, the total disability cases in the endocrine system had grown to 247,324, and 86 percent of that total was Vietnam era veterans.⁵³

Today, with the ongoing conflict in Iraq and the Persian Gulf, presumptions continue to be an issue. As the IOM report on presumptions states:

Three major legislative actions by Congress have influenced the recent presumptive decisions—the Radiation-Exposed Veterans Compensation Act of 1988, the Agent Orange Act of 1991, and the Persian Gulf War Public Laws of 1995 and 1998. The concept of “at least as likely as not” in regard to exposure potential was introduced for radiation exposures and its use has since been extended. The Agent Orange Act grew out of the events following the Vietnam War and expresses substantial and significant elements of the presumptive story. The presumptions put in place by Congress for Gulf War illnesses represent the first time that Congress produced a list of health outcomes that it defined as “undiagnosed illnesses.”⁵⁴

Clearly, the history of presumptions shows that an expert review of the presumptive decision-making process was needed. This Commission therefore tasked IOM to evaluate the VA’s presumptive disability decision-making process

⁵³ Veterans Benefits Administration, *Annual Reports*, 2004, 2005.

⁵⁴ Institute of Medicine (IOM), *Presumptive Disability Decision-Making*, Summary, 9.

and, if needed, recommend a more rigorous scientific model to underpin the decision process. Specifically, IOM was asked to

Describe and evaluate the current model used to recognize diseases that are subject to service connection on a presumptive basis. If appropriate, propose a scientific framework that would justify recognizing or not recognizing conditions as presumptive.⁵⁵

In the Commission's statement to the IOM Committee on the Presumptive Disability Decision-Making (PDDM) Process, the committee was requested to pursue several underlying questions:

- Assess the processes used in the past and at the current time to make decisions on presumptions.
- Provide substantive advice concerning how to ensure that this situation (inability to document exposure to biological, chemical, radiological, or other environmental agents) is not repeated in the future.
- Consider if a different methodology should be used in determining causal relationships other than the environmental aspect used for the current method.
- Provide advice, from an epidemiological and statistical standpoint, on what strength of evidence would be the appropriate requirement when the Secretary of VA considers whether to establish a presumption.

The IOM convened the Committee on the Presumptive Disability Decision-Making (PDDM) Process in May 2006. The committee consisted of 14 members and a small number of consultants and staff. After deliberating for about 16 months, holding three public meetings, and conducting 10 case studies, the committee made 19 recommendations. The Commission supports these findings and endorses the committee's recommendations, with a few caveats. First, the Commission suggests consideration of combining this advisory committee with the other advisory committee also recommended by IOM regarding the Rating Schedule in order to streamline the process, which is further discussed in Chapter 4 of the IOM PDDM report. Secondly, the Commission is concerned over the use of causal effect rather than association as the criteria for decision and encourages further exploration. Finally, during its deliberations, the Commission discussed the possibility of paying benefits on a proportional basis, but concluded that implementing such a payment scheme would not be practical. With these caveats in mind, the IOM committee's recommendations, as adopted by the Commission, are the following:

Recommendation 5.8

⁵⁵ Ibid., 2

Congress should create a formal advisory committee (Advisory Committee) to the VA to consider and advise the Secretary of VA on disability-related questions requiring scientific research and review to assist in the consideration of possible presumptions. [IOM Rec. 1]

Recommendation 5.9

Congress should authorize a permanent independent review body (Science Review Board) operating with a well-defined process that will use evaluation criteria as outlined in this committee's recommendations to evaluate scientific evidence for VA's use in considering future service-connected presumptions. [IOM Rec. 2]

Recommendation 5.10

VA should develop and publish a formal process for consideration of disability presumptions that is uniform and transparent and that clearly sets forth all evidence considered and the reasons for decisions reached. [IOM Rec. 3]

Recommendation 5.11

The goal of the presumptive disability decision-making process should be to ensure compensation for veterans whose diseases are caused by military service and this goal must serve as the foundation for the work of the Science Review Board. The committee recommends that the Science Review Board implement its proposed two-step process. [IOM Rec. 4]

Recommendation 5.12

The Science Review Board should use the proposed four-level classification scheme, as follows, in the first step of its evaluation. A standard should be adopted for "causal effect" such that if there is at least as much evidence in favor of the exposure having a causal effect on the severity or frequency of disease as there is evidence against, then a service-connected presumption will be considered. [IOM Rec. 5]

- **Sufficient:** The evidence is sufficient to conclude that a causal relationship exists.
- **Equipose and Above:** The evidence is sufficient to conclude that a causal relationship is at least as likely as

not, but not sufficient to conclude that a causal relationship exists.

- **Below Equipose:** The evidence is not sufficient to conclude that a causal relationship is at least as likely as not, or is not sufficient to make a scientifically informed judgment.
- **Against:** The evidence suggests the lack of a causal relationship.

Recommendation 5.13

A broad spectrum of evidence, including epidemiologic, animal, and mechanistic data, should be considered when evaluating causation. [IOM Rec. 6]

Recommendation 5.14

When the causal evidence is at Equipose and Above, an estimate also should be made of the size of the causal effect among those exposed. [IOM Rec. 7]

Recommendation 5.15

The relative risk and exposure prevalence should be used to estimate an attributable fraction for the disease in the military setting (i.e., service-attributable fraction). [IOM Rec. 8]

Recommendation 5.16

Inventory research related to the health of veterans, including research funded by DoD and VA and research funded by the National Institutes of Health and other organizations. [IOM Rec. 9]

Recommendation 5.17

Develop a strategic plan for research on the health of veterans, particularly those returning from conflicts in the gulf and Afghanistan. [IOM Rec. 10]

Recommendation 5.18

Develop a plan for augmenting research capability within DoD and VA to more systematically generate evidence on the health of veterans. [IOM Rec. 11]

Recommendation 5.19

Assess the potential for enhancing research through record linkage using the DOD and VA administrative and health record databases. [IOM Rec. 12]

Recommendation 5.20

Conduct a critical evaluation of gulf war troop tracking and environmental exposure monitoring data so that improvements can be made in this key DoD strategy for characterizing exposures during deployment. [IOM Rec. 13]

Recommendation 5.21

Establish registries of service members and veterans based on exposure, deployment, and disease histories. [IOM Rec. 14]

Recommendation 5.22

Develop a plan for an overall integrated surveillance strategy for the health of service members and veterans. [IOM Rec. 15]

Recommendation 5.23

Improve the data linkage between the electronic health record data systems used by DoD and VA—including capabilities for handling individual soldier exposure information that is included as part of the individual's health record. [IOM Rec. 16]

Recommendation 5.24

Ensure implementation of the DoD strategy for improved exposure assessment and exposure data collection. [IOM Rec. 17]

Recommendation 5.25

Develop a data interface that allows VA to access the electronic exposure data systems used by DoD. [IOM Rec. 18]

Recommendation 5.26

DoD and VA should establish and implement mechanisms to identify, monitor, track, and medically treat individuals involved in research and other activities that have been classified and are secret. [IOM Rec. 19]

A discussion of the IOM report recommendations is provided below.

II.2 A New Framework for Presumptions

The case studies illustrated to the IOM committee that review approaches have shifted over time, that the target of review panels has vacillated between causation and association, and procedures precluded reexamination of presumptive decisions, even in the face of dynamic evidence. These findings “point to multiple points in the process of establishing presumptions that, in the committee’s view, should be modified by its participants.” The report goes on to state “the committee has concluded that there is a basis for making changes to the present approach. Building on the conceptual foundation developed in these earlier chapters, the committee addresses the second part of its charge in this chapter and recommends a framework for establishing presumptions in the future.”⁵⁶

Their recommended framework

has multiple new elements: a process for proposing exposures and illnesses for review; a systematic evidence review process incorporating a new evidence classification scheme and quantification of the extent of disease attributable to an exposure; a transparent decision-making process by VA; and an organizational structure to support the process.⁵⁷

The foundation of this new, proposed framework rests in the recommended establishment of two new panels: an Advisory Committee and a Science Review Board. These new panels would ensure a consistent approach to considering exposure reviews, making recommendations to the Secretary of VA, providing an independent expert review of evidence for causation, and estimating the service-attributable fraction of disease. This would be conducted in an open, public forum. The IOM committee offers substantial detail about the structure and the roles of the two proposed panels.

Under the IOM committee recommendation, the Advisory Committee would be chartered by Congress. It would be a permanent committee. It would be composed of veterans’ representatives and recognized and credible experts in relevant medical and scientific fields. The committee would receive support from VA and other federal staff.

⁵⁶ Ibid., 12-1.

⁵⁷ Ibid.

The primary role of the Advisory Committee would be to identify potential exposures during military service and related disabilities that might be caused by these exposures; then to refer these topics, as appropriate, for comprehensive review by the Science Review Board.

Under the IOM committee's construct, the Advisory Committee would review the initial assessment and make recommendations on further review to the Secretary of VA. The Secretary of VA would have the authority to select conditions and agents for full review by the Science Review Board.

The Advisory Committee would accept proposals from any source on behalf of affected veterans. It is anticipated that proposals would be accompanied by supporting information. The Advisory Committee would establish a standard procedure for screening proposals, obtaining additional input, and completing their assessment.

The IOM committee places the VA and the Secretary of VA firmly in the center of the proposed assessment process. VA would support the Advisory Committee; VA would receive Advisory Committee recommendations and consider them. The IOM committee specifies that VA would "consider the nature and extent of evidence, number of veterans potentially affected, severity of the conditions, public comment, and potentially other factors to decide the topics that would proceed to the Science Review Board."⁵⁸

The IOM committee further specifies that the Secretary of VA would be required to respond formally to the Advisory Committee's recommendations with an annual copy forwarded to Congress. The Secretary of VA would forward those topics deemed appropriate for further review to the Science Review Board. Ultimately, the Secretary of VA would receive the comprehensive scientific evaluations completed by the Science Review Board and decide on presumptions.

The IOM committee states strongly that the current presumptive review process has been flawed by not being open enough. The IOM committee found that "VA (1) has no formal published rules governing this process, (2) does not thoroughly disclose and discuss what "other" medical and scientific information it considered, and (3) publishes abbreviated and insufficiently informative explanations of why a presumption was or was not granted."⁵⁹

⁵⁸ Ibid., 12-10.

⁵⁹ Ibid., 13-3.

The committee repeatedly makes the point that “VA must establish a uniform and transparent process for making decisions with regard to presumptions.”⁶⁰ This mandate for a public process includes a public protocol for the internal review of reports received from the Science Review Board. It also includes publication of review notices and requests for pertinent information in the *Federal Register*, and possibly on the VA Web site.

Like the Advisory Committee, the IOM report envisions the Science Review Board being chartered by Congress and funded by VA. The Science Review Board would be an independent body made up of experts in key disciplines. The group would be supported by a staff of professionals with expertise in relevant disciplines. The Science Review Board would develop standard operating procedures for its evidence reviews and categorizations. As with the other elements in the new proposed framework, the efforts of the Science Review Board would be “transparent.”

The IOM committee makes the point that evaluations conducted under the new proposed framework would routinely be subject to rereview and updating. The committee suggests that these rereviews could follow a fixed cycle, or be triggered by new compelling scientific information.⁶¹

This Commission strongly agrees with the need for a new framework for presumptive decision making. The Commission also endorses the fundamental elements proposed by the IOM committee. Establishment of an Advisory Committee and an independent Science Review Board will add much needed expertise and standardization to the presumptive review process. The openness of the new process and the regular involvement of stakeholders will be key to its success.

This Commission will make specific recommendations to Congress regarding the establishment of the Advisory Committee and the Science Review Board. The Commission urges that these committees be authorized quickly and that standard operating procedures reflecting the IOM committee recommendations be promulgated by VA and the Science Review Board as soon as practicable.

II.3 Causation as Basis for Presumptions

The IOM committee stated clearly that one of the most critical matters under its review was clarifying the basis for presumptive decision making. Their report

⁶⁰ Ibid., 12-10.

⁶¹ Ibid., 12-9 to 12-13.

discusses this issue exhaustively and makes a compelling case that association is inadequate as the presumptive decision basis. The IOM committee's discussion makes it clear, as summarized below, that evidence for association can sometimes be misleading, even if the association appears to be strong.

Chapter 4 of IOM's report on presumptive disability decision making (PDDM) discusses the legislative background on presumptions. This discussion makes it clear that the standard for establishing presumptions has evolved, and from time to time, it has been confusing.

The Veterans' Dioxin and Radiation Exposure Compensation Standards Act (Pub. L. No. 98-542, Stat. 2725) was passed in 1984. Among other things, this legislation required the Secretary of VA to promulgate guidelines and standards for determining whether claims based on exposure to Agent Orange were service connected. When the VA did issue final regulations, they reflected the need for a cause-and-effect relationship to establish a presumption.

Later, in the case of *Nehmer vs. United States* (1989, U.S. District Court for the Northern District of California, Case Number 86-6160: pp. 7–9) the court concluded "that Congress did not intend VA to use a causal relationship," but suggested that "service connection...be granted on the basis of 'an increased risk of incidence,' or a 'significant correlation' between dioxin and various diseases."⁶²

When Congress passed the Agent Orange Act of 1991 it stated that VA should "prescribe regulations providing for a presumption whenever the Secretary determines, on the basis of sound medical and scientific evidence, that a positive association exists..." However, in mandating a contract with the National Academy of Sciences, Congress also charged them to determine "whether there exists a plausible biological mechanism or other evidence of a causal relationship between herbicide exposure and disease."⁶³

The basis for establishing presumptions became less clear when the first IOM Agent Orange committee placed its data findings into the following four categories: sufficient evidence of an association; limited/suggestive evidence of an association; inadequate/insufficient evidence to determine whether an association exists; limited/suggestive evidence of no association. These categories did not provide a clear dividing line for establishing or denying a presumption. Initially, VA did not establish presumptions for cancer categorized

⁶² Ibid., 4-6.

⁶³ Ibid., 4-6, 4-7.

in the “limited/suggestive” category. However, upon analysis of the second IOM review (1996), VA did decide to grant presumptive service connection for prostate cancer, which was categorized as “limited/suggestive.”

This winding historical path demonstrates that the basis for presumptions has been unstable and not clearly understood. From this point the IOM committee makes the case for a new, clear standard.

The IOM’s PDDM report states:

Provision of compensation to a veteran, or to any other individual who has been injured, on a presumptive basis requires a *general* decision as to whether the agent or exposure of concern has the potential to *cause* the condition or disease for which compensation is to be provided in at least some individuals, and a *specific* decision as to whether the agent or exposure has caused the condition or disease in the particular individual or group of individuals. The determination of causation for veterans is based on review and evaluation of all relevant evidence including: (1) measurements and estimates of exposures of military personnel during their service, if available, (2) direct evidence on risks for disease in relation to exposure from epidemiologic studies of military personnel, (3) other relevant evidence, including findings from epidemiologic studies of nonmilitary populations who have had exposure to the agent of interest or to similar agents, and (4) findings relevant to plausibility from experimental and laboratory research.⁶⁴

The IOM committee goes on to make a basic assertion regarding presumptive service connection; namely that when “a veteran has a specific medical disease, the primary question for presumptive compensation is whether the disability is *attributable*, that is, caused by exposures during military service.” They assert that the basic question is whether, absent service, the disability would have occurred at all or would have been less severe.⁶⁵

The committee also draws a clear distinction between association and causation. They state that association is not the same thing as causation. Association is *prima facie* evidence for causation, but not sufficient for proving a causal relationship between exposure and disease. They use an interesting example to show the difference: In the early 1950s, Doll and Hill did a study on cigarette smoking and lung cancer. Although they did not record its presence, Doll and

⁶⁴ Ibid., 6-2.

⁶⁵ Ibid., 6-4.

Hill would presumably have found a high positive association between having tar-stained fingers and lung cancer mortality in their study. Clearly having tar stains on one's fingers does not by itself *cause* lung cancer. If it did, lung cancer could have been reduced by prescribing tar-solvent soap. This is an example of a spurious association, and the IOM highlights it to show that association—by itself—is inadequate for determining presumptive service connection.

II.4 Categorization of Evidence

Having determined that causation should be the standard for presumptive decision making, the IOM committee looked at categorization of the evidence of causation. As stated above, the prior categories, and their interpretation, had shifted from time to time. So, a new set of categories was clearly needed. The IOM committee recommended the following categories, which are based on causation, and the VA's longstanding policy to grant benefit of the doubt to veterans.

1. **Sufficient:** The evidence is sufficient to conclude that a causal relationship exists.
2. **Equipoise and Above:** The evidence is sufficient to conclude that a causal relationship is at least as likely as not, but not sufficient to conclude that a causal relationship exists.
3. **Below Equipoise:** The evidence is not sufficient to conclude that a causal relationship is at least as likely as not, or is not sufficient to make a scientifically informed judgment.
4. **Against:** The evidence suggests the lack of a causal relationship.

In contrast to the categories used previously by IOM Agent Orange committees, the new categories above provide a clear delineation for granting or denying a presumption. The new, proposed categories also allow for movement along the categorical scale as new scientific evidence is made available. Under the old scheme, there was initial reluctance to declare an association based on a finding of "limited/suggestive" evidence. However, as time progressed and additional reviews were done, decisions gravitated toward a position where "limited/suggestive" evidence was considered adequate to declare a presumption.

Use of the prior set of categories also led to another dilemma. Under these earlier categories, a disease would be categorized as having "limited/suggested" evidence of an association with exposure if a single significant study showed a correlation. Because of this definition, results of future scientific studies could not change the categorization of the disease. As the IOM's PDDM committee states:

The categorization of the evidence as “limited/suggestive” by IOM has led to presumptions on the part of VA that appear to be irreversible once made, even though scientific evidence is dynamic. Stated in another way, even if further scientific evidence were unsupportive of previous research findings and a future IOM committee were to change its classification for strength of evidence, VA may not change its presumption.⁶⁶

The IOM committee recommendations remove any reference to the strength of a single study. The IOM report also uses language, such as “equipose” and “at least as likely as not,” that is familiar to VA claims examiners. There is a long-standing policy at VA to give the veteran the benefit of the doubt. This concept has been confirmed through substantial case law that documents “equipose” and “at least as likely as not” as the appropriate threshold for finding service connection and granting benefits claims.

This Commission believes the new proposed categories of evidence are far clearer than the prior set, and that promulgation of this new categorization will contribute to more fair and consistent results.

II.5 Scope of Scientific Reviews

In several places the IOM report notes that, in the past, reviews that preceded a finding of presumptive service connection have been limited in their scope. The case study on Agent Orange and prostate cancer includes the following statement: “The IOM Agent Orange committees have tended to rely largely on epidemiologic findings for the evidentiary classifications.” In the same section the IOM report goes on to quote the 2003 IOM Agent Orange report: “On the basis of its evaluation of the epidemiologic evidence reviewed in this and previous reports on veterans and Agent Orange, the committee finds...The evidence regarding association is drawn from occupational studies in which subjects were exposed to a variety of pesticides, herbicides, and herbicide components and from studies of Vietnam veterans.”⁶⁷

Another example of limited scope is provided in the case study on amputees and cardiovascular disease. The case study found that “The scientific basis for this presumption was a single retrospective study of World War II veterans conducted by Medical Follow-Up Agency.”⁶⁸

⁶⁶ Ibid., 5-17.

⁶⁷ IOM, *Presumptive Disability Decision-Making, Case Study (CS) 8-3*.

⁶⁸ Ibid., CS 4-5.

The IOM committee firmly states that a broad range of evidence must be reviewed:

Provision of compensation to a veteran, or to any other individual who has been injured, on a presumptive basis requires a *general* decision as to whether the agent or exposure of concern has the potential to *cause* the condition or disease for which compensation is to be provided in at least some individuals, and a *specific* decision as to whether the agent or exposure has caused the condition or disease in the particular individual or group of individuals. The determination of causation for veterans is based on review and evaluation of all relevant evidence including: (1) measurements and estimates of exposures of military personnel during their service, if available, (2) direct evidence on risks for disease in relation to exposure from epidemiologic studies of military personnel, (3) other relevant evidence, including findings for epidemiologic studies of nonmilitary populations who have had exposure to the agent of interest or to similar agents, and (4) findings relevant to plausibility from experimental and laboratory research.⁶⁹

The report then discusses various types of studies and their relative values.

The IOM committee provides significant narrative on the value of randomized controlled trials as a method for determining causation. They give this type of scientific evaluation very high marks. The IOM committee indicates that this design illustrates the kind of evidence they would like to have to assess causal claims. The randomized controlled trial allows the technician to directly observe the response of the same person when they are treated and not treated, so that the treatment can be reasonably inferred to be the “cause” of any differences in response under the two conditions.

The IOM committee also asserts the value of observational studies while acknowledging this type of study lacks many of the advantages of controlled studies. Then, the IOM committee discusses toxicological studies, animal studies, and mechanistic investigations, citing examples. Their conclusion is that data from each of these types of studies on how a given agent causes a health effect can be sufficiently convincing to support a causal conclusion. They can and should be used to clarify the findings and associations seen in epidemiological studies, and to draw more reliable conclusions regarding causation.⁷⁰

⁶⁹ IOM, *Presumptive Disability Decision-Making*, 6-2.

⁷⁰ *Ibid.*, 7-3–7-5.

IOM's PDDM report discusses at great length the concept of service-attributable fraction (SAF), and recommends its use in the presumptive decision-making process. The attributable fraction (AF) is described as "the proportion of disease in an exposed group that can be attributed to the exposure...the AF is interpreted as the probability that among the exposed people with the disease, their disease has actually been caused by the exposure."⁷¹ Calculating the SAF allows an examiner to gain an estimate of risk in assigning a presumption by comparing the rates of disability among those exposed and unexposed to a given risk agent. Use of this tool would help determine the risk of error if a presumption were assigned to a given exposure/disease relationship.

The strength of association between exposure and disease is typically measured with a statistic called the *relative risk* (RR). RR compares the incidence of disease among the exposed to the incidence in the unexposed. The ratio shows incidence of those exposed as the numerator, and the incidence of those not exposed as the denominator. A relative risk of 1.0 means that the frequency of disease among the exposed is the same as among the unexposed. A relative risk of 10 means that the rate of disease among the exposed is ten times as high as among the unexposed.⁷² The IOM committee advocates use of this statistic in conjunction with the others, to quantify findings.

Ultimately, the IOM committee recommends use of the entire spectrum of evidence in evaluating causation. Their assertion is that relying on one (or few) sources of information limits the result reliability, and each type of analysis discussed can help to build the strongest possible case for or against causation.

This commission agrees that a broader spectrum of evidence should be used in assessing presumptive service connection. This should be reflected in the charters of the Advisory Committee and the Science Review Board, and in their standard operating procedures.

II.6 Inventory Research Related to the Health of Veterans

The IOM committee devotes an entire chapter of its report to gathering, storing, and sharing data between DoD and VA. The picture presented is of large organizations trying to capture important information, but in disjointed fashion. The disconnections are in methods, technology used in data collection and storage, and in organizational priorities.

⁷¹ Ibid., 9-1.

⁷² Ibid., 7-5.

The IOM committee report laid the groundwork about inventory research needs earlier in the report—in Chapter 6:

Military personnel sustain a variety of exposures, some specific to the military and others not, that may increase risk for disease. If exposures of potential concern were tracked during military service and disease surveillance were in place and maintained, even for those who have left active duty, evidence could be generated directly relevant to the causation of disease in veterans. Lacking such evidence, reviewers turn to epidemiological studies of other populations and gauge the relevance of the findings for the exposures of veterans. Such groups also give consideration to toxicological and other research information. For a specific individual, the determination of eligibility for compensation would be based ideally in full knowledge of that individual's risk and an estimation of his or her probability of causation, given exposure history and observational information on the associated risk from similarly exposed people. However, this level of information and scientific understanding has not yet been fully achieved for individual causation for any agent.⁷³

Another statement found in the case study summary on mental disorders strengthens the case for broader research. Among the “Lessons Learned” from that case study were the following:

Presumptive decisions for mental disorders have been made for veterans who are former POWs and veterans who developed chronic mental problems during or shortly after military service. Although legislation has been informed by the scientific evidence available at the time, the scientific evidence in some instances has been limited and with inconsistency around the disorders included. For example, if the strength of evidence classification of limited/suggestive evidence leads to presumptive decisions for PTSD, dysthymia, and any anxiety state among former POWs, then there does not appear to be a clear basis for excluding other mental disorders with equal or stronger evidence of connection to being a POW, such as major depression. The presumptive decisions established in regard to the previously mentioned mental disorders make clear that these decisions have been influenced by not only scientific evidence, but political and social considerations that apply to these veterans (e.g., POWS) and the specific mental disorders they manifest. The need to develop a stronger evidence base and consistent evaluation of the evidence base with regard to these disorders is great, particularly in light of the anticipated high rates of mental disorders among military personnel assigned to and

⁷³ Ibid., 6-3.

returning from Iraq and Afghanistan. This case study also illustrates the need for a process to continually carry out research and update the scientific base for presumptions.⁷⁴

Chapter 10 of the IOM report catalogues a series of data collection systems managed by DoD, VA, and other entities. These include the DoD routine health assessments, event-driven assessments, and deployment-specific health assessments. It also includes DoD exposure assessments, VA-sponsored epidemiologic studies, as well as non-VA sponsored studies about veterans' health. As these listings progress, it becomes evident there has been a huge amount of information gathered about veterans' health. The efforts continue, and are even expanding, by the various stakeholders. However, it also becomes evident that improved *coordination* of effort is going to be needed.

In summarizing the findings in this report chapter, the IOM committee states that DoD and VA are clearly intent on improving the breadth, depth, and availability of health and exposure data, but much work is required. The committee offers a long series of recommendations to facilitate that desired improvement. These recommendations range from supporting the implementation of DOEHRS (Defense Occupational and Environmental Health Readiness System) to improved, periodic surveillance of active-duty servicemen (including exposure assessments) to better data linkages between DoD and VA.

The 11 report recommendations relating to health and exposure data are sorted into six areas of "important findings:"

1. Ensure that DOEHRS is implemented as planned.
2. Improve the interface between the electronic health record data systems used by DoD and VA—including capabilities for handling individual exposure information that is included as part of a soldier's health record.
3. Develop an interface that allows the VA to access the electronic exposure data systems used by DoD.
4. Develop DoD policy to ensure that classification/declassification (secrecy) issues are managed appropriately for both DoD and the veteran.

⁷⁴ Ibid., 5-3.

5. Strengthen the assessment of psychological stressors and symptoms.
6. Establish registries of service members and veterans based on exposure, deployment, and disease histories.⁷⁵

The IOM committee felt strongly enough about the DOEHRS system implementation that it recommended “this Commission work through Congress to establish a specific DoD budget line for the DOEHRS implementation, including the appropriate training of personnel in exposure assessment and in use of the system, and that Congress receive annual reports from DoD on the status of DOEHRS development and implementation.”⁷⁶

This Commission notes the IOM committee’s emphasis on DOEHRS development and also recognizes recent attempts by VA and DoD to improve communications and data sharing in other areas. The establishment of the Joint Executive Council (JEC) and its subordinate bodies, the Health Executive Council (HEC) and the Benefits Executive Council (BEC), are evidence of this renewed joint interest. Improvements must be made, though. The Commission supports all of the recommendations of the IOM committee on improved data collection, storage, and sharing (shown as Recommendations 9 through 19, in Chapter 13 of the IOM report). The large number of these data-related recommendations is a reflection of the complexity of the systems and related issues.

The Commission takes special note, though, of IOM Recommendation #15: Develop a plan for an overall integrated surveillance strategy for the health of service members and veterans. This step is critical to the entire process; without it, more and better data gathering probably will not have the anticipated results. As the IOM report states in Chapter 10, the

activity must be jointly well managed by DoD and VA. A strong central organization, staffed jointly by DoD and VA with external expert advisors, should be given responsibility for the ongoing evaluation of health and exposure data quality, the regular review of registry and surveillance activities, the definition of surveillance and research strategies, and the coordination of surveillance and research projects. This joint DoD-VA soldier and veteran exposure and health surveillance organization would have broad responsibility for oversight of all DoD and VA surveillance and

⁷⁵ Ibid., 10-27–10-38.

⁷⁶ Ibid., 13-7.

research activities whether they are conducted internally or externally by those organizations.⁷⁷

Several key words and phrases jump out from this excerpt: “jointly well managed...strong central organization...broad responsibility for oversight of all DoD and VA surveillance.” These concepts will be hard to establish and maintain; they run contrary to many of the current organizations’ structures and culture. But it must be done. Fair, compassionate, timely service to our disabled veterans requires a holistic approach in this area.

II.7 Conclusion

The above narrative represents a very brief summary of the IOM committee report *Improving the Presumptive Disability Decision-Making Process for Veterans*, along with this Commission’s reaction to their findings. The IOM committee clearly did an exhaustive review of the subject. As stated previously, this Commission generally endorses the IOM committee recommendations with two exceptions. The Commission is concerned that the recommended threshold of causation rather than association may be too stringent. In addition, the Commission suggests combining the Advisory Committee on presumptions with the Advisory Committee recommended by IOM on the Rating Schedule.

What needs to be done constitutes a major renovation of the presumptive decision-making process. The findings and recommendations of this IOM committee will save time and steps in the renovation process. They have already provided the outline:

1. Build a new framework for presumptions.
2. Recognize causation as the basis for presumptions.
3. Clarify the categorization of evidence.
4. Expand the scope of scientific reviews related to the presumptive decision-making process.
5. Expand and substantially improve coordination of the research related to the health of veterans.

⁷⁷ Ibid., 10-39.

II.8 Environmental and Occupational Hazards

II.8.A Agent Orange and Blue Water Veterans

II.8.A.a Issue

By statute (38 U.S.C. § 1116 [2006]), disabilities resulting from certain illnesses are service connected for Vietnam veterans due to presumed exposure to certain chemicals found in herbicides, such as Agent Orange. That is, veterans who served in Vietnam between January 9, 1962, and May 7, 1975, (the Vietnam Era) are “presumed to have been exposed during such service to an herbicide agent” (38 C.F.R. § 3.307[a][6][iii] [2006]) If such a veteran is subsequently disabled by an illness that VA recognizes is an effect of such exposure, the veteran may receive presumptive service connection for that disability. At issue is whether offshore (“blue water”) Navy veterans of the Vietnam Era, who were never physically on Vietnamese soil, are entitled to presumptive herbicide exposure or presumptive service-connected status for certain illnesses connected to indirect herbicide exposure.

There are a number of federal statutes and regulations that apply to this issue. The first, 38 U.S.C. § 1116(f), states:

For purposes of establishing service connection for a disability or death resulting from exposure to an herbicide agent, including a presumption of service connection under this section, a veteran who, during active military, naval, or air service, served in the Republic of Vietnam during the period beginning on January 9, 1962, and ending on May 7, 1975, shall be presumed to have been exposed during such service to an herbicide agent containing dioxin or 2,4-dichlorophenoxyacetic acid, and may be presumed to have been exposed during such service to any other chemical compound in an herbicide agent, unless there is affirmative evidence to establish that the veteran was not exposed to any such agent during that service.

That is, any veteran who “served in the Republic of Vietnam” during the Vietnam Era is presumed to have been exposed to herbicides during that service. As noted above, if such a veteran is diagnosed with certain illnesses, it is presumed that those illnesses were caused by herbicide exposure. The difficulty arises in defining the phrase, “served in the Republic of Vietnam.” Prior to 1997, the VA M21-1 *Adjudication Procedure Manual* noted that receipt of the Vietnam Service Medal, which was awarded to all service members, including some blue water veterans, who served in or near Vietnam during the Vietnam Era, was adequate evidence of service in Vietnam. The Vietnam Service Medal was therefore used as an indication that the veteran had also been exposed to herbicides.

In 1997, VA General Counsel issued VAOPGCPREC 27-97 in an attempt to clarify the definition of “Vietnam Era,” found in 38 U.S.C. § 101(29)(A). General Counsel held that blue water veterans who were never physically in Vietnam should not be included within the set of service members who “served in Vietnam during the Vietnam Era.” As a result, blue water veterans were not eligible for presumptive herbicide exposure without first demonstrating that they set foot in Vietnam. The General Counsel first stated that the language of 38 U.S.C. § 101(29) is so vague that one must “look beyond the terms of the statute” for a definitive understanding of it.⁷⁸ The General Counsel went on to examine the report by the Senate Committee on Veteran’s Affairs concerning 38 U.S.C. 101(29), which states that the code should apply “only with respect to those veterans who actually served *within the borders* of the Republic of Vietnam during that time frame.”⁷⁹ Given this legislative history, the VA General Counsel determined that the wording of 38 U.S.C. § 101(29) must be interpreted to indicate that “service on a deep-water naval vessel in waters off the shore of the Republic of Vietnam does not constitute service in the Republic of Vietnam.”⁸⁰

In 2006, the United States Court of Appeals for Veterans Claims decided the case of *Haas v. Nicholson*, ruling that blue water veterans should, in fact, be granted presumptive herbicide exposure. The court ruled that it is unclear which definition Congress intended to use for “service in Vietnam,” and that the legislative history of the relevant regulations is similarly ambiguous (*Haas v. Nicholson*, Vet. App. 04-0491, 10–11, 16 [U.S. Court of Appeals for Veterans Claims 2006]). In addition, the court found that VA has not been consistent in using a single definition for “service in Vietnam,” and that it has misunderstood federal regulations (*Haas v. Nicholson*, p. 21). The court concluded that:

VA's regulation defining "service in the Republic of Vietnam," 38 C.F.R. § 3.307(a)(6)(iii), is permissible...however, the regulation is ambiguous. VA's argued interpretation of the regulatory term "service in the Republic of Vietnam," affording the application of the presumption of exposure to herbicides only to Vietnam-era veterans who set foot on land and not to the appellant, is inconsistent with long-standing agency views, plainly erroneous in light of legislative and regulatory history, and unreasonable, and must be SET ASIDE. In this case, the M21-1 provision allowing for the application of the presumption of exposure to herbicides based on the receipt of the VSM controls (*Haas v. Nicholson*, p. 31).

Therefore, based on this most recent ruling, presumptive herbicide exposure is to be granted to any veteran who was awarded the Vietnam Service Medal, including blue water Navy veterans. On March 7, 2007, the Solicitor General

⁷⁸ VA General Council, *VAOPGCPREC 27-97*, 2.

⁷⁹ *Ibid.*, 3.

⁸⁰ *Ibid.*, 5.

approved the Secretary of VA's appeal of this decision to the Court of Appeals for the Federal Circuit, originally filed in October 2006. Therefore, all *Haas* cases will continue to be held under a stay in processing until the appeal is adjudicated.

II.8.A.b Findings

The guidelines governing presumptive herbicide exposure for Vietnam Era veterans are numerous and, in many ways, confusing. Due to this confusion, along with the ambiguous legislative history of the presumption, federal courts recently ruled that any veteran who received the Vietnam Service Medal should be presumed to have been exposed to herbicides during military service. Although this decision is currently under appeal, if it is upheld, blue water Navy veterans will be granted service connection for disabilities related to Agent Orange.

II.8.B Fort McClellan and PCB Exposure Risks

II.8.B.a Issue

At the May 19, 2006, meeting of the Veterans' Disability Benefits Commission, a veteran raised the issue of PCBs (polychlorinated biphenyls) and other chemical exposures at the U.S. Army installation at Fort McClellan, Alabama, between 1954 and 1978. Other veterans who have experienced ill health have provided comments at Commission meetings and site visits regarding the chemical exposure issue at Ft. McClellan. The Monsanto Chemical Plant in Anniston, Alabama, located a few miles from Fort McClellan, manufactured PCBs that polluted the water, soil, and air. By the time class action lawsuits were filed against the company, Fort McClellan veterans had separated from service and were unavailable or unaware of the Anniston health registry.

PCBs were used in a wide range of commercial and industrial applications, but production of PCBs declined in the late 1970s because of apparent health and environmental risks associated with the chemical compound. The health risks associated with PCBs differ depending on the chemical concentration strength. Skin conditions such as chloracne or other rashes are the most common health effect of PCB exposure. Tests on animals have revealed other health effects associated with PCBs. These include diseases of the liver, stomach, and thyroid gland; adverse effects on the immune system; behavioral alterations; and reproductive disorders. The Department of Health and Human Services (HHS), the Environmental Protection Agency (EPA) and the International Agency for Research on Cancer (IARC) agree that there is some correlation between exposure to PCBs and higher cancer rates.⁸¹ Table 5.4 delineates the health risks of PCBs.

⁸¹ EPA, "Health Effects of PCB."

Table 5.4 PCB Health Risks

Type of Risk	Condition	Study Organization
Known	Skin conditions: - Rashes - Chloracne	EPA
Associated	Injuries of the: - Liver - Stomach - Thyroid gland Changes to immune system Changes in behavior Impaired reproduction	EPA, HHS
Being studied	Cancer risk Neurological health impacts Diabetes	HHS, EPA, IARC CDC, ATSDR ^a CDC, ATSDR

^a Agency for Toxic Substances and Disease Registry.

The Monsanto Company (Monsanto-Solutia and now Solutia Inc.) bought Swann's Anniston facility in 1935. The factory became a major producer of PCBs from 1935 to 1971. Residents of Anniston claim that the company knowingly dumped PCBs into a nearby river as well as buried chemicals in the landfill. In 1996 the PCB levels in the community exceeded the limits established by the Federal Government. In certain areas, levels were as high as "940 times the federal level of concern in yard soils, 200 times that level in dust inside residential homes, 2,000 times that level in Monsanto's drainage ditches."⁸² Numerous lawsuits were filed against the company in the 1990s accusing it of knowingly polluting the Anniston community during the production of PCBs and related chemical compounds.

Bowie v. Monsanto (CV-2001-832 [Etowah County Cir. 1996]), which began in 1996, led to a class action lawsuit and settlement by Solutia Inc. Facing as much as \$3 billion in legal and compensatory damages, the company "reached a \$700 million settlement with citizens of Anniston, Alabama, who claimed PCB releases caused an assortment of health problems."⁸³ According to company documents that were produced at the trial, the company "flushed tens of thousands of pounds of PCBs into nearby creeks...and buried millions of pounds in a hillside

⁸² Grunwald, "Monsanto Hid Decades of PCB Pollution."

⁸³ Taylor, "Solutia Settles Alabama PCB Case."

landfill.”⁸⁴ Realizing that environmental damage had been done, Monsanto spent approximately \$40 million on cleanup before the trial and plans to continue that work. During the trial, one member of Monsanto said: “Regardless of the result in this case, we’re committed to doing what’s fair to deal properly with the impacts of previous PCB production at our plant.”⁸⁵

Fort McClellan was an expansive base that became a center for training service members beginning in World War II and continuing through Vietnam. The Women’s Army Corps (WAC) School was founded at Fort McClellan on September 25, 1952, and remained the leading training program for women until the school and center closed on May 13, 1977. Fort McClellan was also home to the U.S. Army Chemical Center and School, the U.S. Army Combat Developments Command Chemical Biological-Radiological Agency, and an advanced individual training infantry brigade. The Base Realignment and Closure process closed Fort McClellan on May 20, 1999. The Army must conduct extensive cleanup at Fort McClellan because it is a Superfund site under the Comprehensive Environmental Response, Compensation, and Liability Act due to the chemicals used on the post.

There are numerous cleanup activities taking place in Anniston, Alabama, due to the pollution caused by the Monsanto Company. According to the EPA, Solutia entered into an administrative order on consent (AOC) with the EPA to test properties for possible PCB contamination. Additionally, on March 25, 2002, the EPA and Solutia completed negotiations for a “remedial investigation/feasibility study.” The consent decree “requires Solutia to perform a comprehensive study and evaluation of risks to human health and the environment caused by PCBs”⁸⁶ and calls for the establishment of a \$3.2 million foundation to support special education needs for the area’s children. Military children may be included in this study if they still live in the Anniston area. However, if they have relocated with their families to other states, they will not be included.

The Agency for Toxic Substance and Disease Registry (ATSDR) at the Center for Disease Control and Prevention (CDC) completed a study of the Anniston area in 2000. The study found that “exposures to PCBs in soil in parts of Anniston present a public health hazard” and lead to both cancerous and noncancerous results in people with a “prolonged exposure” to PCBs.⁸⁷ Furthermore, “PCBs in residential soils in some areas may present a public health hazard for thyroid and neurodevelopmental effects after exposure durations of less than 1 year.”⁸⁸ ATSDR recommended further studies to

⁸⁴ Firestone, “Alabama Jury Says Monsanto Polluted Town.”

⁸⁵ Ibid.

⁸⁶ Gaillard, “Alabama NPL/NPL Caliber Cleanup Site Summaries.”

⁸⁷ Agency for Toxic Substance and Disease Registry, “Health Consultation Evaluation.”

⁸⁸ Ibid.

elucidate the amount of PCBs still present in the community and the health effects associated with it.

Recently, ATSDR awarded Jacksonville State University funding for a number of studies that are being performed by the Anniston/Calhoun Research Consortium. The consortium consists of a dozen universities and includes residents of Anniston, but not military personnel, unless they were still living in the area at the time the study began. The group is performing four studies:

- **Community Health Survey**—This survey will randomly select 1,250 individuals from the affected and surrounding area. There will be a field visit as well as an office visit in which each individual will undergo an interview and a medical evaluation. Within this survey is a study for diabetes in which 400 individuals (200 studied and 200 used as a control) will undergo further blood testing.
- **Neurocognitive Study**—Three hundred children (approximately 270 have been studied thus far) between the ages of 11 and 15 are being investigated for PCB exposure and learning effects. The group is performing a 3-hour test and blood will be drawn. Parents (the mother ideally) will also undergo blood testing.
- **Focus Group Study**—This effort will study the attitudes in the community.
- **Geospatial Modeling**—This study will acquire and study geospatial modeling and PCB data from the EPA. Geospatial modeling involves researchers partitioning the ground into nearly equal sized blocks of land, taking samples, and assessing the extent to which the ground is polluted.

The studies are currently budgeted at approximately \$3.2 million. The consortium is in the final phase of data collection and analysis, but it does not have an estimated time of publication at this point.⁸⁹

On July 13, 2006, the DoD completed an information paper regarding PCB contamination at Fort McClellan. DoD concluded that “there is little or no environmental contamination at Ft. McClellan that may have exposed Army personnel at Ft. McClellan to PCBs.”⁹⁰ Instead, the paper argues that contamination from the Solutia plant is located in Anniston, which is “on the other side of Anniston from the Anniston Army Depot and Ft. McClellan. There is no direct pathway from the contaminated sites to either installation.”⁹¹ The only group of military personnel that DoD cited as possibly exposed to PCBs are those “who have previously resided or currently reside within the identified

⁸⁹ Shelton, Christie, phone conversation June 29, 2006.

⁹⁰ DoD, “PCB Contamination Sources at Ft. McClellan,” 2.

⁹¹ *Ibid.*

contaminated areas in Anniston."⁹² DoD recognizes that the town of Anniston has been polluted and that further study is needed.

DoD identifies the Solutia Inc. plant as the major polluter of PCBs in the Anniston area. Citing an ATSDR study, DoD concluded that "exposures to PCBs in the soil in parts of Anniston present a public health hazard" especially for "thyroid and neurodevelopment effects after exposure durations of less than 1 year."⁹³ ATSDR stated that it was limited by data gaps and needed to study the area further, but DoD maintains that Army personnel on the base were not affected. In 2002, ATSDR, the state of Alabama, and "local health departments informed residents of the contamination by one of several means" including direct communication, "public availability sessions," and a public information campaign in the local news media.⁹⁴ DoD did not state whether it contacted service members who had been stationed at Ft. McClellan.

II.8.B.b Findings

There is a possibility that service members who trained at Fort McClellan from 1935 until 1971 (and later depending on environmental contamination) came into contact with PCBs from the Monsanto Chemical Plant because of the base's proximity to Anniston and service members' participation in social and recreational activities in the town. The production of PCBs and the subsequent dumping performed by the company led to environmental and health damages in the area. Solutia settled class action lawsuits brought against it by civilians and faces tremendous cleanup costs as a result of PCB pollution in the Anniston area.

It is difficult to estimate the amount of PCBs or other chemicals to which service members might have been exposed during their time at Fort McClellan. VA service-connected disability is possible for service members that might have been exposed to PCBs while serving at Fort McClellan. There might be veterans who served at Fort McClellan who are service connected for medical conditions that might or might not be related to PCB exposure. However, since there is no VA registry of this information, a correlation cannot be determined. VA would need to create a registry to track health trends in these veterans to help determine whether a correlation exists between specific medical conditions and exposure to chemicals at the base.

The Commission contracted with the Institute of Medicine to assess the past process for establishing presumptions and to recommend improvements. The

⁹² Ibid.

⁹³ Ibid., 1–2.

⁹⁴ Ibid., 2.

Commission's contract with IOM did not include assessments of any diseases such as those that might be the result of exposure to PCBs.

Although there are known health consequences in the Anniston area, these risks have not been directly linked to PCB exposure during service at the post. Veterans who served from 1935 to 1971 (and beyond) may be suffering from disabilities relating to PCBs without knowing that their illnesses may be related to this exposure. However, further testing for the presence of PCBs in the Anniston area and on the post and an epidemiological analysis would be needed to determine if there is sufficient justification for a presumption.

The full extent of PCB contamination in Anniston is not yet fully known. The cleanup and investigations being undertaken by EPA, CDC, ATSDR, and the Anniston/Calhoun Research Consortium are only beginning to elucidate the amount and effects of PCB pollution on the local community and on military personnel who might have been exposed while serving at Fort McClellan.

The Commission believes it is the responsibility of VA to initiate appropriate actions to create registries, monitor ongoing studies, and contract with an organization such as IOM, as needed, for further analysis and recommendations. The Ft. McClellan situation illustrates the critical need for the improved process for presumptions recommended by the IOM's PDDM committee.

II.8.C Chemical Exposure at Camp Lejeune

II.8.C.a Issue

In 1980, water tests at Camp Lejeune, North Carolina, revealed elevated levels of trichloroethylene (TCE) and tetrachloroethylene (PCE), two common industrial contaminants used as degreasers and dry-cleaning agents, in one of the base's water-treatment plants. Further testing in 1981 and 1982 revealed similarly elevated levels of those contaminants in two treatment plants, and a systematic sampling of the base's entire water supply revealed widespread contamination. As a result, during 1984 and 1985, the base closed 10 of its ground wells.⁹⁵ It is unclear to what extent, if any, exposure to these chemicals affected the health of the service members and their families who were stationed at Camp Lejeune while the contaminated wells were in service.

The Agency for Toxic Substances and Disease Registry (ATSDR) has initiated a number of scientific studies into the possible health effects of volatile organic

⁹⁵ U.S. Marine Corps, *Report to the Commandant*, 1.

compound (VOC) exposure on Camp Lejeune residents. A 1997 ATSDR scientific survey concluded that there is no scientific evidence to support the claim that VOC exposure at the levels present at Camp Lejeune would cause adverse health reactions in adults. However, that report also noted that, while there is not enough scientific evidence to be conclusive, VOC exposure may have adversely affected fetuses, since they are especially susceptible to the adverse effects of contamination and may be affected by lower doses of a contaminant than adults.⁹⁶ This prompted another ATSDR study, released in 1998, which concluded that, in certain circumstances, exposure to VOCs at Camp Lejeune made certain women more likely to give birth to underweight infants than unexposed women in similar circumstances.⁹⁷ Another preliminary study surveyed the parents of 12,598 children who may have been exposed to VOCs at Camp Lejeune and found that 103 of them suffered from birth defects or childhood cancers, which are the most likely results of VOC exposure in children.⁹⁸

Based on these previous studies, ATSDR is currently engaged in a more comprehensive examination of the effects of VOC exposure at Camp Lejeune on fetuses. To date there have been no completed scientific studies into the health effects of VOC exposure at Camp Lejeune on adults or children, primarily because existing scientific evidence indicates that the level of contaminant and length of exposure that existed at the base were not sufficient enough to have an impact on the health of adults. The current study is looking into the 103 reported cases of birth defects and cancers, and once this initial study is finished, a comprehensive study will be initiated to establish whether a link exists between the drinking water at Camp Lejeune and birth defects or childhood cancers.⁹⁹ If this report reveals a link between the contaminated water at Camp Lejeune and adverse health effects among fetuses, then it may be necessary to initiate a scientific survey to firmly establish whether or not a similar link can be made for adults.

In addition, the Senate recently passed the 2007 Defense Appropriations Bill, which contains an amendment calling for an immediate study of the Camp Lejeune contamination by the National Academy of Sciences. The study team will perform a meta-review of all available “scientific and medical evidence [to] assess the strength of that evidence in establishing a link or association between exposure to [TCE] and [PCE] and each birth defect or disease suspected to be associated with such exposure.” The study must be initiated within 60 days of the bill’s passing, then completed and submitted to Congress and the Navy within

⁹⁶ Agency for Toxic Substance and Disease Registry, *Public Health Assessment*.

⁹⁷ Agency for Toxic Substance and Disease Registry, *Volatile Organic Compounds*.

⁹⁸ Agency for Toxic Substance and Disease Registry, *Survey of Specific Childhood Cancers*.

⁹⁹ *Ibid.*

18 months of initiation (*National Defense Authorization Act for Fiscal Year 2007*, S. 2766, Amend. 4349, 109th Cong.).

II.8.C.b Findings

As of this writing, all medical studies of the Camp Lejeune TCE VOC issue remain ongoing. There have been preliminary reports on the water-modeling issue, which aims to produce a working model of the contamination pattern in the base's water system. The first results from this study were expected to be released in June 2007, to include an interactive Web site where veterans stationed at Camp Lejeune during the period of contamination may input where and when they lived on base, and receive the water model's estimate of their contamination. In June 2007, ATSDR released the Executive Summary of this report, which provides an overview of the contamination pattern, along with information to allow former Camp Lejeune residents to determine if they were exposed to the contaminants. This report will be used by ATSDR in its study of the contamination's effect on fetal and infant development.¹⁰⁰ In May 2007, GAO also released a report on this issue. This report provides a thorough overview of the issue and its history, and examines the ongoing ATSDR study. The experts interviewed by GAO largely approve of the structure of the study, but point out several adjustments that could make the study more effective and efficient.¹⁰¹ Since the ongoing health studies have not been completed, GAO's report is confined to an overview of existing information.

The Commission is satisfied that the Marine Corps seems to be responsive to the contamination issue at Camp Lejeune and that the current studies should be able to shed light onto this issue once they are completed.

Recommendation 5.27

VA should consider environmental issues such as blue water Navy and Agent Orange, Ft. McClellan and polychlorinated biphenyls, and Camp Lejeune and trichloroethylene/tetrachloroethylene in the new presumptions framework.

III PTSD and Other Mental Health Disorders

This section discusses VA claims issues related to PTSD and, to a lesser extent, other mental disorders. Because the number of cases of PTSD is increasing faster than any other disabilities encountered by VA in both the number of veterans and the monetary value of benefits paid, the Commission wants to

¹⁰⁰ Agency for Toxic Substance and Disease Registry, *Analyses of Groundwater Flow*.

¹⁰¹ GAO, *Defense Health Care*, 8–9.

ensure that PTSD claimants are evaluated fairly and consistently, in accordance with modern medical diagnostic techniques.

A 2005 report by the VA Office of the Inspector General summarized the trends in PTSD claims and compensation from FY 1999–2004.¹⁰² The report identified the following trends:

During FYs 1999–2004, the number and percentage of PTSD cases grew significantly. While the total number of all veterans receiving disability compensation grew by only 12.3 percent, the number of PTSD cases grew by 79.5 percent, increasing from 120,265 cases in FY 1999 to 215,871 cases in FY 2004. During the same period, PTSD benefits payments increased 148.8 percent from \$1.72 billion to \$4.28 billion. Compensation for all other disability categories only increased by 41.7 percent. While veterans being compensated for PTSD represented only 8.7 percent of all claims, they received 20.5 percent of all compensation benefits.¹⁰³

Data tables provided to IOM from VA confirm these trends. Specifically, these tables show that as of September 30, 2005, the number of veterans with PTSD on VA disability rolls had risen to 244,846; and the monthly value of those payments was \$347,867,708. VA treatment for PTSD has been provided to over 345,000 veterans. This means PTSD is by far the costliest disability for the VA Disability Compensation Program. The next costliest disability (as shown by the VA tables) is intervertebral disc syndrome, which carried a monthly value of \$87,027,144.

The cost of disability payments alone for PTSD would warrant serious study of the processes associated with PTSD. But there are other issues as well. The Inspector General study cited above also showed significant variability in payments for PTSD (and other disabilities) among states, and there have been ongoing concerns about the methods used to diagnose PTSD, and the consistency of implementing those methods. A primary methodological issue has been the type and thoroughness of the medical examinations done in connection with PTSD disability claims. Finally, the appropriateness and viability of the VA Schedule for Rating Disabilities (Rating Schedule) has been questioned. This area was studied in depth by the IOM Committee on PTSD Compensation and Military Service.

¹⁰² VA Office of the Inspector General, *Review of State Variances*.

¹⁰³ *Ibid.*

III.1 Diagnosis and Assessment of PTSD

VA asked IOM to conduct a study on the diagnosis and assessment of, and treatment and compensation for, PTSD.

The IOM committee that undertook the study of diagnosis, assessment, and treatments for PTSD decided to separate its work into two parts. The first part, on diagnosis and assessment, was completed in 2006 and published as *Posttraumatic Stress Disorder: Diagnosis and Assessment*. A second study, on treatment, is in progress and will be published at a later date.

The IOM report on PTSD diagnosis and assessment contains several significant findings. These include:

- Confirmation of the description and current diagnostic criteria for PTSD. The current diagnostic criteria for PTSD are provided in DSM-IV; it includes several components. Those components are exposure to a traumatic event, intrusive reexperiencing of the event, avoidance and numbing, hyperarousal, at least a month of symptoms, and clinically significant distress or impairment that was not present before the trauma.
- The optimum approach to PTSD diagnosis is a face-to-face interview in a confidential setting, done by a health professional experienced in the diagnosis of psychiatric disorders, such as a psychiatrist, psychologist, clinical social worker, or psychiatric nurse.¹⁰⁴
- The PTSD diagnostic interview should elicit the patient's symptoms, assess the history of potentially traumatic events, and determine whether the patient meets the DSM-IV criteria for PTSD and the frequency and severity of symptoms. It should also determine whether there are comorbid psychiatric and medical conditions.¹⁰⁵
- Adequate time must be allocated for the PTSD assessment. "Depending on the mental and physical health of the veteran, the veteran's willingness and capacity to work with the health professional, and the presence of comorbid disorders, the process of diagnosis and assessment will likely take at least an hour or could take many hours to complete."¹⁰⁶
- The instruments for assessing symptom severity do not provide diagnostic criteria for PTSD and should not be used in lieu of a comprehensive clinical interview. The report also stated that screening instruments are helpful for identifying people who might have a disease but are not very

¹⁰⁴ IOM, *Posttraumatic Stress Disorder*, 16–17.

¹⁰⁵ *Ibid.*, 17.

¹⁰⁶ *Ibid.*, 17.

useful for assessing disorder progression, prognosis, or treatment efficacy.¹⁰⁷

There are several significant items from the IOM *Posttraumatic Stress Disorder: Diagnosis and Assessment* report that the Commission endorses.

The diagnostic criteria for PTSD published in DSM-IV are sufficient for use by the VA Disability Compensation Program. Those criteria are clear, comprehensive, and generally accepted by the medical community. VA must adhere to these diagnostic criteria in conducting its medical evaluations and in assigning disability evaluations. When VA revises its disability rating criteria for PTSD, it must closely follow the diagnostic criteria in DSM-IV and its revisions by its publisher, the American Psychiatric Association.

In compensation examinations for PTSD, VA already conducts face-to-face interviews, with experienced health professionals. Generally, for mental health exams, the professional who conducts a compensation and pension (C&P) exam must be clinically privileged. Mental health examiner qualifications include:

- Board-certified psychiatrists
- Licensed doctorate-level psychologists
- Doctorate-level mental health providers under close supervision by a board-certified psychiatrist or a licensed doctorate-level psychologist
- Psychiatry residents under close supervision by a board-certified, or board-eligible, psychiatrist or a licensed doctorate-level psychologist

In addition, other mental health professionals with appropriate clinical credentials may perform review exams or exams related to claims for increased benefits. Specifically, licensed clinical social workers, nurse practitioners, clinical nurse specialists, and physician assistants under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist may perform, review, or increase C&P mental disorder exams.¹⁰⁸ The Commission believes that this requirement should be continued.

The Commission is not persuaded that current VA exams are as uniformly thorough as recommended by IOM. VA should review its protocols for PTSD exams and mandate the kind of comprehensive exam described in the IOM report. This would include elicitation of the patient's symptoms, assessment of

¹⁰⁷ Ibid., 34.

¹⁰⁸ VBA Fast Letter 06-03.

the history of potentially traumatic events, and determination as to whether the patient meets the DSM-IV criteria for PTSD. The interview should also determine the frequency and severity of symptoms and the associated disability. It should also determine whether there are comorbid psychiatric and medical conditions. This will require allocation of sufficient time for each exam and interview. Strict quality control methods should be mandated to assure appropriate exam completion.

VA should mandate the use of assessment tools, such as the *Best Practice Manual for Posttraumatic Stress Disorder Compensation and Pension Examinations*. There are several instruments that include screening tools, diagnostic instruments, and trauma and symptom severity scales. Clinicians can choose to administer structured or semistructured interviews or self-report instruments. The Commission urges VA to standardize and mandate the use of appropriate tools in conjunction with the clinical interview, and describe the circumstances under which they are to be used. Guidance should be published emphasizing that use of assessment tools does not eliminate the need for a face-to-face interview with the veteran or claimant.

III.2 Compensation for PTSD

On behalf of the Commission, VA's Veterans Benefits Administration (VBA) asked the National Academies to convene a committee of experts to address the following issues:

- VA's compensation practices for PTSD, including examining the criteria for establishing severity of PTSD as published in the *Schedule for Rating Disabilities*;
- the basis for assigning a specific level of compensation to specific severity levels and how changes in the frequency and intensity of symptoms affect compensation practices for PTSD;
- how VA's compensation practices and reevaluation requirements for PTSD compare with those of other chronic conditions that have periods of remission and return of symptoms; and
- strategies used to support recovery and return to function in patients with PTSD.¹⁰⁹

The IOM study *PTSD: Compensation and Military Service* was published in May 2007. It was broader in scope than the study on diagnosis and assessment. The PTSD compensation study reviewed the medical examination process, the Rating Schedule criteria used to assign disability ratings, the status of training for

¹⁰⁹ IOM, *PTSD Compensation*, S-2.

medical professionals and claims examiners, incentives and disincentives to recovery (including consideration of regular reexaminations and protection of some payment level), and data management. The IOM committee findings and recommendations are listed below, followed by associated justification and discussion:¹¹⁰

1. The Global Assessment of Functioning (GAF) score has limited usefulness in assessing PTSD as a disability for compensation. Therefore, VA should first ensure that its mental health professionals are well informed about the uses and limitations of the GAF and trained to implement it in a consistent and uniform manner. Secondly, VA should identify and implement an appropriate replacement for the GAF.
2. A standardized training program should be developed for clinicians conducting C&P evaluations for PTSD. Training should emphasize diagnostic criteria and comorbid conditions with overlapping symptoms, and it should include example cases that illustrate appropriate documentation of exam results for C&P purposes.
3. The choice to conduct psychological testing and which tests are appropriate should be left at the discretion of the examining clinician.
4. The Rating Schedule criteria for rating mental disorders are at best crude and overly general for the assessment of PTSD disability and do not use consistent criteria for rating remitting or relapsing conditions. New Rating Schedule criteria specific to rating PTSD based on the DSM-IV should be developed and implemented. A multidimensional framework for characterizing PTSD disability should be considered when formulating these criteria.
5. VA should establish a specific certification program for raters who deal with PTSD claims; VA should also provide the training to support the certification program and periodic recertification.
6. Data fields recording the application and reevaluation of benefits should be preserved over time rather than being overwritten when final determinations are made. Data should also be gathered at two points in the process where there is currently little information available: when claims are made and after compensation decisions are rendered.
7. VA should consider instituting a fixed long-term minimum level of benefits that would be available to any veteran with service-connected PTSD at or above some specified rating level without regard to that person's state of health at a particular point in time after the C&P examination. (In this context, IOM meant benefits in a broad context, not only compensation.)

¹¹⁰ Ibid., S-4-S-9.

8. The determination of whether and when reevaluations of PTSD beneficiaries are carried out should be made on a case-by-case basis using information developed in a clinical setting. Specific guidance on the criteria for such decisions should be established so that these can be administered in a fair and consistent manner.
9. VBA should collect and analyze data on reevaluations so that the system can be improved in the future.
10. VA should conduct more detailed data gathering on determinants of service connection and rating levels for military sexual assault-related PTSD claims and develop and disseminate reference materials for raters that more thoroughly address the management of such claims.
11. More research is also needed on gender differences regarding vulnerability to PTSD.

The following discussion is based on the recommendations of the report of the IOM Committee on PTSD Compensation and Military Service.

The IOM report on PTSD compensation discussed various problems with the GAF score. The report states, "One of the many problems with the GAF is that it was derived from a scale used for the study of affective disorders and psychosocial function across a broad range of psychiatric conditions." The report further states that "the GAF anchors are conceptually relatively weak," that "reliability is a major concern for the GAF," and that "another weakness of the GAF is that it combines symptom levels with assessment of function and does not allow for a separation of these two areas."¹¹¹ Ultimately, this second IOM committee concluded that the GAF score has limited usefulness in the assessment of the level of disability for PTSD compensation, and that its emphasis on the symptoms of mood disorder and schizophrenia and its limited range of symptom content diminish its applicability to PTSD. However, they acknowledged that eliminating the GAF could be disruptive because it is widely used. This conclusion led to their recommendation that training be provided to mental health professionals about the limitations of GAF, until such time that VA can identify and implement use of a substitute tool.

As a general observation, the IOM report stated, "The key to proper administration of VA's PTSD compensation program is a thorough C&P clinical examination conducted by an experienced professional."¹¹² The report goes on to cite the recommendation from the IOM report on diagnosis and assessment and endorse it by inclusion. The report emphasizes this need while

¹¹¹ Ibid., 4-6, 4-7.

¹¹² Ibid., S-9.

acknowledging that doing more consistently detailed exams may result in increased up-front costs.

“PTSD is marked by high rates of comorbidity,” which complicates the evaluation process.¹¹³ As a result of this finding, the IOM committee recommended a standardized training program for clinicians who conduct C&P psychiatric evaluations. Their recommended training program would emphasize diagnostic criteria for PTSD and comorbid conditions with overlapping symptoms.¹¹⁴

The Rating Schedule requires separate evaluation, and therefore separating symptoms and effects, of comorbid disorders.¹¹⁵ The IOM report on PTSD Compensation states that there is a scientific basis for defining PTSD and other conditions (e.g., depression) as discrete disorders. Further, the report states that clinicians doing C&P exams have described having difficulty in dealing with comorbid mental disorders. This is largely because the rating specialists who interpret the C&P exams need to attribute portions of the common symptoms to each rated disorder. This led to the recommendation that a national standardized training program be developed for clinicians.

The IOM committee criticized the Rating Schedule in several aspects:

the committee did not identify a strong evidence basis for assigning any percentages to any particular disorder. Second, because each disorder has a unique set of symptoms, complications, objective findings, prognostic features, and treatment options and efficacy, there may be little or no common basis on which to make a comparison among disorders. Third, it is apparent that the ratings for each disease category were derived by the specialists responsible for documenting and describing the disease...Not only may different specialists view their particular sets of diseases differently, it is not clear that any cross-communication took place among different specialists in an effort to calibrate percentage ratings across diseases.

The IOM report goes on to conclude that seemingly similar conditions, such as chronic fatigue syndrome and fibromyalgia, can have widely disparate ratings.¹¹⁶

The report also compares the Rating Schedule criteria for rating mental disorders with those for rating physical disorders and makes several criticisms, namely:

¹¹³ Ibid., 4.

¹¹⁴ Ibid., S-3.

¹¹⁵ Ibid., 4-8.

¹¹⁶ Ibid., 5-11.

1. There is one general rating scheme that is applied to all type of mental disorders (schizophrenia, mood, and anxiety disorders), which makes it necessary to lump together heterogeneous symptoms from multiple conditions into a single spectrum. Although other groups of disorders are handled with one general rating scheme, such as disorders of the spine, female reproductive system, and renal disease, this “lumping” is carried to an extreme in the case of mental disorders.
2. Some of the secondary factors shown in Table 5.6 of that report (objective findings; deformity; physical complications) that may influence percentage ratings cannot be met for mental disorders. This could theoretically put mental disorders at a relative disadvantage compared to physical disorders in terms of achieving higher percentage ratings.
3. Two important threshold levels for increases in disability benefits—40 percent and 60 percent—cannot be assigned to mental disorders.
4. Occupational and social impairment (OSI) is the central factor used in determining each level of disability for mental disorders. However, little guidance is given about how to measure either OSI or its differential impairment across different percentage ratings. Furthermore, the various secondary factors that are used in rating physical disorders (Table 5.6) are not applied to mental disorder ratings, which give OSI a disproportionately high value in determining the ratings.”¹¹⁷

The IOM committee offered an alternative rating scheme for PTSD.¹¹⁸ The committee’s framework is distinguished from the current rating criteria in that five dimensions are assessed in rating disability: symptoms, psychosocial functional impairment, occupational functional impairment, treatment factors, and health-related quality of life. The framework’s approach to occupational functional impairment illustrates an approach that should reduce or avoid disincentives to return to work. Also, “it specifies that the psychosocial and occupational aspects of functional impairment be separately evaluated and that a claimant be rated on the dimension on which he or she is more affected.”¹¹⁹

The recommendation regarding a certification program for raters flows from discussion on the subjectivity, variability of results, and deficiencies associated with the current Rating Schedule criteria for rating mental disorders. Their specific conclusion is that

Determining ratings for mental disabilities in general and for PTSD specifically is more difficult than for many other disorders because

¹¹⁷ Ibid., 5-13, 5-14.

¹¹⁸ Ibid., Table 5-11.

¹¹⁹ Ibid., 5-21.

of the inherently subjective nature of symptom reporting. To promote more accurate, consistent, and uniform PTSD disability ratings, the committee recommends that VA establish a specific certification program for raters who deal with PTSD claims, with the training to support it, as well as periodic recertification.¹²⁰

Furthermore, the IOM committee suggests that this training and certification requirement lends itself to consideration of specialization—that “some ratings be done at a facility other than the one closest to the veteran in order to ensure that a qualified rater performs the evaluation.”¹²¹ The committee did not elevate this concept to a recommendation.

The recommendation about improved data collection resulted from the committee’s conclusion that there are gaps in VA’s current data collection process. The committee received substantial data about the characteristics of PTSD beneficiaries, but found that additional information that could have been helpful in their deliberations was not available. The committee felt that additional information about veterans’ medical and physical status prior to their claim for benefits, and similar information tracked after claim decisions would be useful in future analyses of PTSD disability compensation issues.

The recommendation about a fixed long-term minimum level of benefits developed from the discussion about barriers or disincentives to recovery, and the effect of compensation on recovery.¹²²

The IOM report cited lack of a veteran’s postsecondary education and training as a major barrier to recovery. It also acknowledged that use of the GI Bill has shown positive effects in earning power for eligible veterans.¹²³

The IOM report also discussed the issue of unintended consequences in disability income support policies; that they often contribute to underemployment and unemployment. It elaborates the problem that both private and public disability compensation systems often have regulations that mandate an administrative review of the individual’s disability status upon return to work. The report adds that “research has indicated that people with psychiatric disabilities are aware of these disincentives and report that they plan their labor force participation accordingly.” The IOM report further discusses changes to the Medicaid program as well as the SSI/SSDI programs to alleviate this problem.

¹²⁰ Ibid., 5-24.

¹²¹ Ibid.

¹²² Ibid., 6-2–6-16.

¹²³ Ibid., 6-2.

IOM concluded that there are many barriers to recovery for veterans diagnosed with PTSD and “there are no easy solutions: experience with civilian benefits systems has shown that the problems will be difficult to remedy.”¹²⁴

The IOM report also mitigates these concerns by noting “there is also some evidence that receiving service-connected disability for PTSD actually encourages individuals to seek mental health treatment. Unpublished research by Sayer and colleagues indicates that the claim process may make it easier to gain access to medical services and that being awarded disability status for PTSD may facilitate access to mental health services.”¹²⁵

The IOM report goes on to state the following:

Although it may seem logical that secondary-gain considerations would create obstacles and disincentives for therapy or treatment among combat veterans, and although there is a body of indirect evidence consistent with this logic, there is little direct evidence that either compensation seeking or receipt of compensation has secondary gain effects on PTSD treatment outcomes. Most empirical studies or trials conducted to date show no relationship between compensation seeking, PTSD disability status, and treatment outcomes.”¹²⁶

The authors of the one study that does show significant differences conclude that

Seeking to obtain or maintain compensation status does not have an inhibiting effect on improvement in treatment among outpatients or among most inpatients. Among inpatients in programs that are designed to provide an extremely long length of stay (100 days on average), however, the motivation to apply for and maintain compensation does appear to inhibit improvement.

The IOM report concludes, “Thus, in spite of concerns that disability compensation for PTSD may create a context in which veterans are reluctant to acknowledge or otherwise manifest therapeutic gains because they have a financial incentive to stay sick, the preponderance of evidence does not support this possibility.”¹²⁷ While some beneficiaries will undoubtedly understate their improvement in the course of pursuing compensation, the scientific literature suggests that such patients are in the minority, and there is some evidence that disability payments may actually contribute to better treatment outcomes in some programs.

¹²⁴ Ibid., 6-3, 6-5.

¹²⁵ Sayer, unpublished manuscript.

¹²⁶ IOM, *PTSD Compensation*, 6-15.

¹²⁷ Ibid.

The IOM committee found that the scheduling of future exams diminished over the period from 1999 to 2006. Scheduling of future exams was found to be “most frequent for those veterans with depression and other mood disorders, PTSD, and fibromyalgia. Veterans with mental disorders as their primary diagnoses accounted for 37 percent of all future exams scheduled in 1999, and those with mental disorders as a primary or secondary diagnosis accounted for 48 percent of all future exams. By 2006, while the future exams continued to be concentrated among beneficiaries with primary or secondary mental disorders, the number of exams dropped sharply. For PTSD primary beneficiaries, the decline was from 14.2 percent to 5.6 percent.”¹²⁸

The reduction in scheduling reexaminations coincided with a period when the VBA claims workload had grown significantly (see Table 5.5). This increasing workload stress must be considered, along with the considerable latitude given to claims examiners in scheduling future exams, when assessing whether VA is appropriately using reexaminations. Regulations indicate that reexaminations should be scheduled “whenever VA determines there is a need to verify either the continued existence or the current severity of a disability. Generally, reexaminations are required if a disability has improved, if evidence indicates that there has been a material change in a disability, or if the current rating may be incorrect” (38 C.F.R. 3.327[a] [2006]). However, the same regulation goes on to list several factors (when the condition has been established as static, when the condition has persisted without material improvement for 5 years, etc.) that place limitations on the need for reexaminations. So, the reduction in future exams could be nothing more than a reaction to workload stress.

Table 5.5 VBA Workload Reports

Fiscal Year	Future Exam Reviews
1999	27,300
2000	25,158
2001	22,252
2002	15,867
2003	9,595
2004	13,533
2005	17,682
2006	51,832

SOURCE: COIN DOOR REPORT 1003, Veterans Service Center, Trend of Completed Compensation and Pension and End Products. 2006.

¹²⁸ Ibid., 5-16.

During that same period, the annual number of rating-related cases performed ranged from 481,000 (in FY 2001) to 839,000 (in FY 2006). These statistics clearly show that scheduling and conducting “future” exams is a very small portion of overall VBA workload.

The IOM committee reached its conclusion that across-the-board periodic reexaminations for veterans with PTSD are not appropriate based on two considerations:

- VA has finite resources to devote to exams and should focus on performance of high-quality initial C&P exams.
- There was no significant misreporting or exaggeration of PTSD symptoms by veterans, and the committee did not wish to single out PTSD claimants for unique and harsher requirements.¹²⁹

The IOM committee acknowledged that disability symptomatology can improve, and that “it is reasonable to consider reexamination after such situations.” The committee concluded, however, that “It would be important to structure reexamination policy in a way that limits disincentives for receiving treatment or rehabilitation services.”¹³⁰

The IOM report discusses the available literature on gender differences in PTSD frequency and the prevalence of sexual assault in the military. It states: “The prevalence of sexual assault in the military is alarming and has been the object of several recent congressional hearings and military reports. A narrative synthesis of 21 studies found that 4.2 percent to 7.3 percent of active-duty military females had experienced a military sexual assault, while 11 percent to 48 percent of female veterans reported having experienced a sexual assault during their time in the military.”¹³¹

The IOM report also states: “In the only study found to address the issue, Murdoch and associates (2003) found that a significantly smaller percentage of females (52 percent) as compared to males (71 percent) had their PTSD deemed to be service connected. This was primarily related to the lower rates of combat exposure among females, with their increased rates of sexual trauma apparently not being taken into account. When military sexual assault was substantiated in

¹²⁹ Ibid., 6-17.

¹³⁰ Ibid., 6-18.

¹³¹ Ibid., 6-19.

the claims file, service-connected PTSD determinations increased substantially."¹³²

The IOM report also acknowledges that there are huge barriers to women being able to independently substantiate military sexual assault, especially in a combat arena. The report states further that very little research exists on the subject of PTSD compensation and female veterans.¹³³

This Commission generally endorses most of the recommendations of the IOM study *Posttraumatic Stress Disorder: Compensation and Military Service*. Collectively, the recommendations offer opportunity for substantial improvement to the VA Disability Compensation Program. The Commission's endorsements and differences are detailed below.

The Commission agrees with the IOM findings about the GAF score. A short-term correction of this issue can and should be made quickly. VA needs to publish internal administrative guidance immediately. This should inform VBA claims examiners and medical professionals involved in C&P examinations about the limitations of GAF and how it can be used until a better instrument is implemented.

Training for clinicians and raters is imperative, as is the need for thorough C&P exams grounded in face-to-face interviews. Some training is already done; this should be reviewed and expanded, as appropriate. The National Center for PTSD should be included in this process. The recommendations on training and conducting C&P exams carry substantial cost, but their importance is high. As VBA and VHA analyze their training and exam needs, they should develop budget requests for ongoing training costs, including dedicated staffing. These budget requests should not wait for the next budgetary request (formulation) cycle; rather they should be submitted immediately as special requests. The need for these measures is critical to the success of the VA Disability Compensation Program. The costs associated with these activities should be considered infrastructure, not new developments.

It is clear that the Rating Schedule criteria for rating mental disorders need substantial revision. Assignment of evaluation levels needs to correlate directly with the basic diagnostic criteria of the disease. The IOM report on PTSD compensation offers a multidimensional approach to PTSD disability rating.¹³⁴ The Commission strongly agrees that disability ratings should reflect more than

¹³² Ibid., 6-21.

¹³³ Ibid., 6-22.

¹³⁴ Ibid., Table 5-11.

“loss of earnings capacity”; the current Rating Schedule already takes additional dimensions into consideration in several areas (for example, disfiguring scars; diagnostic codes 7800–7804) (38 C.F.R. § 4.118 [2006]). The IOM framework includes five dimensions: symptoms, psychosocial functional impairment, occupational functional impairment, treatment factors, and health-related quality of life. This recommendation has implications beyond PTSD. The Commission believes each of these dimensions deserves consideration, and should be incorporated generally into the Rating Schedule. However, the Commission is highly sensitive to the complexity of such changes. VA must be allowed latitude in amending the Rating Schedule so as not to increase its complexity beyond practical utility.

Although the Commission endorses the multidimensional approach proposed by the IOM committee, it does not endorse the establishment of separate tables for each dimension of disability. VA should be permitted to incorporate criteria for any dimension (psychosocial impairment or quality of life, for example) into a single list of evaluation criteria for each disability. It should not be expected that each dimension be described for every condition at every level of disability. The IOM report states, “It is not the intent to require an individual to meet a particular severity level in every dimension in order to qualify for that Rating Schedule disability rating—for example, requiring that an individual be given level III ratings or greater on all five dimensions in order to attain a 50 percent disability rating.”¹³⁵

It is the Commissioners’ belief that building separate tables into the Rating Schedule for each dimension would be overly complex and unwieldy. Such an approach would likely lead to less consistency, rather than more. Further, each dimension will not apply equally for every disability. Discretion should remain with VA to incorporate each dimension as appropriate.

The IOM committee on PTSD compensation recommends a fixed long-term minimum level of benefits that would be available to any veterans with service-connected PTSD. This recommendation grew from the discussion about incentives to recovery in which several studies are described. Some of the studies offer speculative opinions about veterans with PTSD based on civilian study data. However, the IOM report acknowledges mixed results by citing a presentation to the committee that said “data from evaluations of VA programs on the relationship between compensation seeking or disability status and treatment outcomes are inconclusive.”¹³⁶

¹³⁵ Ibid., 5-23.

¹³⁶ Ibid., 6-14.

Current VA policy mandates that “Rating on account of diseases subject to temporary or episodic improvement...will not be reduced on any one examination, except in those instances where all the evidence of record clearly warrants the conclusion that sustained improvement has been demonstrated” (38 C.F.R. 3.344[a] [2006]). Also, the *C&P Procedural Manual* directs claims examiners not to make drastic reductions in evaluations in ratings for psychiatric disorders if a reduction to an intermediate rate is more in agreement with the degree of disability. It goes on to require observation of the general policy of gradually reducing the evaluation to afford the veteran all possible opportunities for adjustment.¹³⁷ So VA policies already reflect an understanding of the sensitivity of rating reductions, as well as their impact. This policy change would take into account the remitting and relapsing nature of PTSD and some other diseases, take another step in VA’s current approach to providing full consideration of veterans’ needs, and increase the protection of veterans from “roller coaster” fluctuations in their ratings. Only when a second medical exam confirms the sustained improvement would an evaluation reduction be proposed. Currently, when VA proposes a reduction in evaluation, it notifies the veteran or claimant of the proposed reduction and the reasons for that reduction. VA allows 60 days for the veteran to respond and present evidence refuting the proposed reduction. If no new evidence is received, then VA takes action to effect the reduction at the end of the month after 60 additional days have elapsed. The VA Disability Compensation Program would benefit from improved incentives to recovery.

The IOM PTSD compensation study declined to make a recommendation for across-the-board reexaminations of PTSD claimants. The report cited the need to focus resources on initial C&P exams, since it found little misrepresentation by PTSD claimants. The Commission believes that reevaluations should occur every 2–3 years to gauge treatment effectiveness and encourage wellness.

III.3 CNA Corporation Findings Pertaining to Mental Disorders and PTSD

CNAC conducted surveys and analysis for this Commission that bear on the VA Disability Compensation Program as it provides for veterans with mental disabilities.

In analyzing quality of life, CNAC found that veterans with mental disorders had significantly lower overall satisfaction with life than veterans with physical disorders. The responses for mental disorders were lower at each level of

¹³⁷ VA, *Adjudication Procedure Manual*, III(iv).

disability, and the difference was significant at each level. Each category of mental and physical disabilities showed similar satisfaction patterns by age, but the satisfaction level averaged about 20 points lower for veterans with mental disabilities.¹³⁸ For example, at 10 percent, physically disabled vets showed overall life satisfaction at 80–85 percent; for 10 percent mentally disabled vets, overall life satisfaction was about 70 percent. At each disability level, the two categories showed similar age patterns, but the satisfaction level was about 20 percent lower for mentally disabled vets.

The CNAC analysis explored the following specific question from its statement of work: “How well do benefits provided to disabled veterans meet the congressional intent of replacing average impairment in earnings capacity?” The conclusion regarding mental conditions reflected significant disparity.

CNAC calculated an earnings ratio to gauge the overall replacement of earnings for veterans receiving disability compensation. This earnings ratio compared the overall earned income with VA compensation (for disabled veterans) with the overall earned income for nondisabled veterans. In the aggregate, they found an earnings ratio of 0.99, which shows very close comparability. However, for PTSD and other mental disabilities, the earnings ratio was much lower.¹³⁹ Specifically, at age 45, the earnings ratios for PTSD were .74 at 10 percent disabled, .78 at 20 to 40 percent, .87 at 50 to 90 percent. The corresponding earnings ratios for musculoskeletal disorders were .99 at 10 percent disabling, 1.02 at 20 to 40 percent, and 1.07 at 50 to 90 percent. Although the earnings ratios for veterans with PTSD were lower than the earnings ratios of veterans with other comparable ratings, the mortality rates for veterans with PTSD were lower (i.e., indicating a healthier status) than the mortality rates of veterans with other comparable ratings. Specifically, the mortality rates for veterans rated 100 percent PTSD are well below the rates for veterans rated 100 percent not PTSD; similarly, the mortality rates for veterans rated for PTSD and Individual Unemployability are well below the rates for veterans rated for Individual Unemployability without PTSD.

In summary, the CNAC analysis of the VA Disability Compensation Program found that the program does provide for reasonable earnings adjustments for most disabling conditions. VA compensation is implicitly awarded to address quality-of-life issues for many disabling conditions, but this does not seem to occur for mental disorders. Therefore, compensation awards for mental disorders do not reflect parity in restoration of earnings or quality of life.

¹³⁸ CNAC, *Final Report*, 66–67.

¹³⁹ CNAC, *Final Report*, 61.

CNAC suggested, as a means to rectify the current disparities for mental disabilities, that ratings for mental disorders be adjusted to a higher level. For example, the disabling effects that currently result in a 10 percent evaluation for a mental disorder would result in a 30 percent evaluation. CNAC cautioned that this suggestion would require a high number of reratings, and that it would not improve parity for those currently rated 100 percent service connected.

CNAC also suggested that VA could increase compensation for veterans who enter the VA Disability Compensation program at a young age, when disparity is high. They suggest this special adjustment could be done by adding a special monthly compensation factor for young entries with mental disabilities.

This Commission agrees that the current compensation disparities for veterans with mental disorders needs correction and believes the best solution is to revise the Rating Schedule criteria for PTSD and other mental disorders. During the revision process, concerns about earnings ratio and a quality-of-life adjustment need to be embedded in the new evaluation criteria. This means that VA will have to conduct additional data analyses to project and then validate the earnings and quality-of-life impacts of these changes. It should also be noted that certain Commission recommendations will improve the incentives inherent in the system for recovery and return to work, which, in turn, will address the compensation and quality-of-life disparities for veterans with mental disorders.

The type of analysis provided by CNAC must be replicated periodically. As changes occur in the future to the Rating Schedule and to medical diagnostic and treatment techniques, the relationships between disability payments and earning capacity, and between disability payments and quality of life, will need to be reevaluated.

As discussed at the beginning of this section, PTSD affects many of our returning veterans, thereby making it a primary concern for this Commission, which chose to address these issues with the assistance of IOM and CNAC. The findings and recommendations of these entities were taken under advisement and were incorporated into the Commission's deliberations. In doing so, the Commission ultimately was concerned with the Rating Schedule criteria for PTSD and other mental disorders; a baseline level of benefits; a holistic approach; the examination process; data collection and research; and examiner training and rater certification. The following recommendations are made by the Commission to improve and integrate VA's process for delivering benefits and services to veterans with PTSD and other mental disorders:

Recommendation 5.28

VA should develop and implement new criteria specific to posttraumatic stress disorder in the VA Schedule for Rating Disabilities. Base those criteria on the *Diagnostic and Statistical Manual of Mental Disorders* and consider a multidimensional framework for characterizing disability caused by posttraumatic stress disorder.

Recommendation 5.29

VA should consider a baseline level of benefits described by the Institute of Medicine to include health care as an incentive for recovery for posttraumatic stress disorder as it relapses and remits.

Recommendation 5.30

VA should establish a holistic approach that couples posttraumatic stress disorder treatment, compensation, and vocational assessment. Reevaluation should occur every 2–3 years to gauge treatment effectiveness and encourage wellness.

Recommendation 5.31

The posttraumatic stress disorder examination process:

- Psychological testing should be conducted at the discretion of the examining clinician.
- VA should identify and implement an appropriate replacement for the Global Assessment of Functioning.

Posttraumatic stress disorder data collection and research:

- VA should conduct more detailed research on military sexual assault and posttraumatic stress disorder and develop and disseminate reference materials for raters.

Recommendation 5.32

A national standardized training program should be developed for VA and VA-contracted clinicians who conduct compensation and pension psychiatric evaluations. This training program should emphasize diagnostic criteria for posttraumatic stress disorder and comorbid conditions with overlapping symptoms, as set forth in the *Diagnostic and Statistical Manual of Mental Disorders*.

Recommendation 5.33

VA should establish a certification program for raters who deal with claims for posttraumatic stress disorder (PTSD), as well as provide

training to support the certification program and periodic recertification. PTSD certification requirements should be regularly reviewed and updated to include medical advances and to reflect lessons learned. The program should provide specialized training on the psychological and medical issues (including comorbidities) that characterize the claimant population, and give guidance on how to appropriately manage commonly encountered rating problems.

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6

Appropriateness of the Benefits

The Commission was charged with evaluating the “appropriateness” of benefits provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service. This has been interpreted to mean evaluating the benefits currently available to U.S. veterans and ensuring that they overcome, to the maximum extent possible, the impact of disability and meet the needs of disabled veterans. The Commission believes that these benefits should rehabilitate veterans in a dignified manner and facilitate their reintegration into the community while compensating them for their impairments of earning capacity, functional impairments, and reduction in quality of life.

The benefits to achieve these goals currently include:

- disability compensation
- special monthly compensation
- aid and attendance/housebound
- clothing allowance
- automobile and adaptive equipment
- specially adapted housing
- healthcare:
 - fee-basis program
 - beneficiary travel
- insurance
- veterans’ preference
- burial and memorial benefits
- vocational rehabilitation and employment (VR&E)

The issue known as *concurrent receipt* is also examined in this chapter.

I Veterans' Disability Compensation

Disability compensation is a monetary benefit paid monthly to veterans who are disabled by injuries or illnesses incurred during, or aggravated by, military service and who are discharged under conditions other than dishonorable. Such disabilities are commonly described as “service connected” once they have been adjudicated by the Department of Veterans Affairs (VA). The compensation payment varies by degree of disability, which is rated from 0 to 100 percent in 10 percent increments (Table 6.1). The monthly benefit includes an additional payment for the dependents of veterans whose disability rating is 30 percent or more. Disability compensation and all related benefits are exempt from federal and state income taxes. More than 2.6 million veterans received VA disability compensation in 2006 (Table 6.2). It is anticipated that more than \$32 billion will be spent in 2008 on disability compensation for veterans with service-connected disabilities (Table 6.3).

Table 6.1 2007 Compensation Rates for Veterans

RATING (%)	MONTHLY PAYMENT (\$)
10	115
20	225
30	348
40	501
50	712
60	901
70	1,135
80	1,319
90	1,483
100	2,471

SOURCE: Department of Veterans Affairs, *Federal Benefits for Veterans and Dependents: 2007 Edition*. Washington, DC: VA, 16.

The clear intent of disability compensation as expressed in statute is to compensate individuals for the “average impairments of earning capacity” resulting from the disability (38 U.S.C. § 1155 2006). However, the Commission believes that disability compensation should also address the impact of impairment on quality of life. The Institute of Medicine’s Committee on Medical Evaluation of Veterans for Disability Compensation reached the same conclusion. The committee wrote,

The purpose of the current veterans' disability compensation program as stated in statute currently is to compensate for average impairment in earning capacity, that is, work disability. This is an unduly restrictive rationale for the program and is inconsistent with current models of disability. The veterans' disability compensation program should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss in quality of life.¹

II Appropriateness of Ancillary and Special-Purpose Benefits

This section examines veterans' ancillary and special-purpose benefits as they relate to compensation for service-connected conditions. The section also analyzes special-purpose benefits, such as health care, insurances, and burial allowances, many of which are for veterans who are not service disabled as well. These ancillary benefits are defined as pertaining to, or deriving from, the entitlement of service-connected benefits.² Ancillary benefits are secondary benefits that are considered when evaluating claims for compensation. Eligibility is contingent on the type and severity of disability of the veteran.³

Veterans suffering from service-connected injuries are the primary recipients of ancillary benefits. Table 6.2 illustrates the number of veterans and dependents who received these benefits in fiscal year (FY) 2006 and the monetary value of each benefit. Table 6.3 illustrates the past, present, and projected future numbers of veterans receiving VA disability compensation and the annual cost. Benefits for survivors are discussed separately.

One of the ancillary benefits for which a veteran with severe disabilities may be eligible is additional compensation called "special monthly compensation" (SMC). These payments include aid and attendance, housebound, and clothing allowances, and are described in depth below.

¹ Institute of Medicine, *21st Century*, 4.

² VA, *M21-1MR*, 2A-7.

³ *Ibid.*, 6B-4.

Table 6.2 Benefits Available to Veterans with Service-Connected Disabilities, Number of Recipients, and Cost, Fiscal Year 2006

VETERANS' BENEFIT		NUMBER OF RECIPIENTS	TOTAL COST
Compensation			
	Veterans	2,683,380	\$26,469,578,000
Clothing allowance		84,990	\$54,412,000
Automotive and adaptive equipment			
	Automobile grants	1,317	\$14,246,000
	Adaptive equipment	7,508	\$36,491,000
Specially adapted housing		593	\$25,780,000
Health care			
	SC ^a 10–20%	495,272	\$2,100,000,000
	SC 30–40% disabling	342,023	\$1,600,000,000
	SC 50% or more disabling	768,537	\$8,100,000,000
	Total service-connected veterans	1,605,832	\$11,800,000,000
Life insurance			
● SGLI ^b death payments		4,558	\$989,358,279
Payments due to	● Service member deaths	2,634	\$898,334,722
Payments due to	● Spouse	847	\$80,263,557
Payments due to	● Child deaths	1,077	\$10,760,000
● TSGLI ^c payments		2,603	\$170,425,000
● S-DVI ^d death payments		5,982	\$61,480,766
● VMLI ^e payments		138	\$9,310,871
Veterans' preference ^f			
	Veterans with preference	410,083	n/a
	Disabled veterans	92,642	n/a
	X > 30% disabled veterans	46,727	n/a
	Total veterans	456,254	n/a

^a SC = service connected^b SGLI = Servicemembers Group Life Insurance^c TSGLI = Traumatic SGLI^d S-DVI = Service-Disabled Veterans' Insurance

^e VMLI = Veterans' Mortgage Life Insurance

^f Only represents the usage of preference within the Federal Government (nonpostal FY 2005).

SOURCES: VA. "Summary Volume IV."

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Table 6.3 Average Monthly Number of Veterans Receiving VA Disability Compensation and Annual Cost, 2000–2018

FISCAL YEAR	NO. OF VETERANS RECEIVING DISABILITY COMPENSATION	COMPENSATION (\$ IN 000s)
2000	2,300,642	15,489,107
2001	2,310,880	16,528,735
2002	2,356,592	18,546,021
2003	2,444,807	20,796,151
2004	2,518,464	22,322,160
2005	2,600,583	24,445,389
2006	2,683,380	26,469,578
2007	2,777,250	29,603,277
2008	2,882,152	32,681,865
2009	3,012,951	35,953,362
2010	3,121,260	38,209,446
2011	3,216,419	40,857,787
2012	3,305,267	43,445,987
2013	3,389,028	46,016,403
2014	3,470,339	48,609,617
2015	3,549,128	51,226,934
2016	3,625,364	53,860,459
2017	3,698,913	56,510,733
2018	3,773,953	59,291,416

SOURCE: FY 2008 Mid-session Review Budget Submission, e-mail from Mark Seastrom to Ray Wilburn, August 1, 2007.

II.1 Special Monthly Compensation (SMC)

VA evaluates and provides SMC to eligible veterans in addition to their 0 to 100 percent combined degree of compensation. To be eligible for this benefit, a veteran must have suffered additional disability specified in the statute as a result of a service-connected disability or be in need of special assistance. The total amount of compensation that veterans receive is calculated at the time their claims are adjudicated by adding the SMC payment to the amount of the schedule compensation rate with the degree of disability. A veteran's SMC payment depends on the nature of the disability. Disabilities fall within subsections of section 1114 of title 38, United States Code, and range from subsection a to subsection s.

There are many possible combinations to calculate a monthly compensation rate. But, as a basic example, if a veteran with a service-connected disability rated at 100 percent were also a below-the-knee amputee, he or she would have a k award and be paid \$2,560 per month. This amount would comprise the FY 2006 100-percent disability compensation rate (\$2,471 per month) and the special monthly compensation for k (\$89 per month) for a total of \$2,560.

SMC differs from other forms of disability compensation in two ways. First, the benefit is associated with noneconomic factors, including personal inconvenience, social inadaptability, and profoundness of disability. Second, VA will consider entitlement to the benefit based on the medical evidence when adjudicating a claim for service connection. (VA considers entitlement to SMC an "inferred issue.") In 2005, 210,148 disabled veterans were receiving SMC awards.⁴

Veterans with catastrophic disabilities and their families face many challenges that make it harder for them to maintain a reasonable standard of living and compete with their peers. SMC adjustments help protect the health and welfare of severely disabled, service-connected veterans and their families. However, after considering the studies conducted by IOM and CNAC and other information, the Commission concluded that there are some instances, such as Aid and Attendance (discussed in the following subsection), in which the level of SMC is inadequate to offset the burden placed on veterans by their disabilities.

Recommendation 6.1

Congress should consider increasing special monthly compensation where appropriate to address the more profound impact on quality of life by the disabilities subject to special monthly compensation and review ancillary benefits to

⁴ C&P Services, *Compensation by SMC*.

determine where additional benefits could improve disabled veterans' quality of life.

II.1.A Aid and Attendance or Housebound

Veterans may be eligible for aid and attendance (A&A) or housebound SMC payments. Under 38 C.F.R. § 3.352(a), the following conditions allow veterans to be considered for regular aid and attendance: (a) they cannot keep themselves ordinarily clean and presentable, (b) they cannot dress and undress themselves, (c) they frequently need adjustment of special prosthetic or orthopedic appliances, which by reason of the particular disability cannot be done without aid, (d) they cannot feed themselves due to the loss of coordination of upper extremities or extreme weakness, (e) they cannot attend to the wants of nature, (f) they have physical or mental issues that prevent them from avoiding the hazards or dangers of daily life.

In determining entitlement to an SMC payment based on the need for aid and attendance, consideration is given to all factors. Accordingly, if a veteran can dress him or herself, but can not attend to the wants of nature, he or she may still be entitled to the higher rate as long as it is determined that he or she is so helpless as to need regular aid and attendance. He or she may then use that money to hire any necessary assistance.⁵

There are three rates for aid and attendance within special monthly compensation. These rates are specified in subsections *l*, *r1*, and *r2*. If the veteran has a single 100-percent schedular-evaluated disability and requires the aid of another person to perform the personal functions required in everyday living, the veteran would be considered for A&A under 38 U.S.C. § 1114 (l). If the veteran is entitled to the maximum rate under either 38 U.S.C. § 1114 (o) or (p) and was in need of regular A&A, the veteran would be considered for A&A under 38 U.S.C. § 1114 (r)(1). If the veteran meets the requirements for *r1* and then clearly establishes the need for supervised daily skilled health care on a continuing basis, the veteran would be considered for a higher A&A benefit under 38 U.S.C. § 1114 (r)(2). These veterans suffer from the most severely disabling conditions and might be bedridden as the result of multiple sclerosis, for example. The rates for *r1* and *r2* are \$6,164 and \$7,070 per month, respectively.

A veteran who is not eligible for aid and attendance might be eligible for housebound care. Under 38 U.S.C. § 1114(s), veterans are eligible for housebound care if they: (a) suffer from service-connected disability, (b) have an

⁵ VA General Counsel, *Ancillary and Special-Purpose Benefits*, 14.

additional service-rated disability or disabilities independently ratable at 60 percent, or (c) are permanently housebound due to a service-connected disability. The amount of compensation available to a single housebound veteran is \$2,766 per month.

The aid and attendance factors are not needs based and reflect the ability to perform functional activities in caring for oneself or managing the surrounding environment. Additionally, the primary focus is on physical impairments and locomotion. Very little emphasis is placed on cognitive (e.g., TBI) or psychological impairments and the needs of those conditions for supervision and management as well as aid and attendance.

Aid and attendance is not extended to the severely injured active duty who are in a medical hold or temporary disability retired list (TDRL) status awaiting discharge but who are in need of a caregiver. Although there are other VA benefits available to the active-duty persons, such as the automobile and housing allowances, aid and attendance is not.

Recommendation 6.2

The amount of payment for aid and attendance should be adjusted to fully pay for the extent of assistance required.

Recommendation 6.3

Extend aid and attendance to severely injured active-duty service members who are in a status pending discharge.

II.2 Clothing Allowance

In 1972, VA was given the authority under Public Law 92-328 to provide a clothing allowance to eligible veterans.⁶ The monetary value of the benefit was initially \$150. During the last 35 years, the clothing allowance benefit has been increased by Congress 33 times to offset inflation. In 2006, VA spent \$54,412,000 on clothing allowances and expects these expenditures to rise to \$61,157,000 for FY 2008.⁷ At this writing, VA is authorized to pay certain service-connected veterans \$662 per year for a clothing allowance.⁸ Veterans accrue this benefit, and are paid yearly on September 1. The benefit is evaluated

⁶ U.S. Congress, "38 U.S.C. § 1162."

⁷ VA, *Budget Summary*, 3A-4.

⁸ VA, "Special Benefits Allowances."

as part of the compensation process and is provided to veterans who use a prosthetic or orthopedic appliance that tends to wear out or tear clothing, or who use prescribed skin medication that causes irreparable damage to outer garments.⁹ A veteran who is hospitalized continues to receive a clothing allowance irrespective of the duration of the hospitalization. A veteran who is incarcerated receives a reduced amount depending on the duration of the incarceration.¹⁰ Essentially, the longer the period of incarceration, the lower the amount of monies provided to veterans for their clothing allowance. The death of a veteran does not terminate the payment of the benefit since it is accrued. In this instance, the allocation of the lump sum payment is payable without pro rata accumulation for any portion of a year in which the veteran died.¹¹

II.3 Automotive and Adaptive Equipment

This benefit is provided to any veteran entitled to compensation under chapter 11 of title 38 and any member of the Armed Forces serving on active duty who has any of the following disabilities, if such disability was the result of an injury or illness incurred or aggravated by military service: (1) loss, or permanent loss of use, of one, or both feet, (2) loss, or permanent loss of use, of one or both hands, and/or (3) permanent impairment of vision of both eyes of the following status: central visual acuity of 20/200 or less in the better eye, with corrective glasses, or central visual acuity of more than 20/200 if there is a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance no greater than 20° in the better eye.

An individual eligible for this benefit may receive a maximum amount of \$11,000 to purchase one automobile. They may also receive an allowance for the purchase of adaptive equipment, which includes power steering, power brakes, power windows, lifts, power seats, and any other special equipment necessary to assist in the health and safety of the veteran, such as air conditioning and/or other interior modification. Veterans are given adaptive equipment for replacement automobiles. Automobile adaptive equipment may be installed or reimbursed on two vehicles every four years. There can be exceptions to this time limit if there are problems with the vehicle, such as fire or theft. A change in the veteran's clinical condition may also warrant new equipment beyond the two-in-four rule. VA can repair any of the equipment it installs, such as hand controls, or any of the equipment it reimburses for, such as an automatic transmission. If the repair costs become excessive (more than half the cost to replace) on the equipment VA installed, it will replace the part with new equipment and not count

⁹ VA, *M21-1MR*, 7-3.

¹⁰ *Ibid.*, 7-4.

¹¹ *Ibid.*, 7-6.

this against the veteran's entitlement. Additionally, veterans who do not receive the grant are still entitled to vehicle entry and exiting equipment. This includes lifts and van modifications, but does not include any operational equipment. Finally, a veteran with severe burns or other skin condition that makes them hypersensitive to sunlight may have tinted windows installed. Table 6.4 contains a history of automobile allowance rates.

Table 6.4 Historical Automobile Allowance Rates

1946	1971	1975	1978	1981	1985	1988
\$1,600	\$2,800	\$3,300	\$3,800	\$4,400	\$5,000	\$5,500
1998	2001	2003				
\$8,000	\$9,000	\$11,000				

SOURCES: PL 79-663, PL 91-666, PL 93-538, PL 95-476, PL 97-66, PL 98-543, PL 105-178, PL 107-103, PL 108-183.

In 2006, VA spent \$14,246,000 on automobile allowances and \$36,494,000 on adaptive assistance. VA projects FY 2008 expenditures of \$14,200,000 on automobile allowance and \$38,800,000 for adaptive assistance.¹²

Current law does not extend this benefit to all service-connected veterans that suffer from burn injuries. Unless the burns are so severe as to render the limb without function and veterans are rated as "loss of use," they do not get the automobile grant and in turn cannot receive reimbursement for operational equipment. However, there is a documented need for this benefit for service-connected veterans with severe burns. The treatment of "burn victims take[s] far longer than for other trauma patients—one to two days for every 1 percent of the body burned."¹³ As a result, veterans with severe burns can face years of therapy. In the interim, they must continue to function in society while dealing with the unwanted attention that comes with the disfigurement of severe burns. Unfortunately, the struggle is made more difficult because the alterations needed to their vehicles are often cost prohibitive.

¹²VA, *Budget Summary*, 3A-14.

¹³ Blankenship, "Treating the Severely Wounded."

II.4 Specially Adapted Housing

This benefit assists veterans or service members to adapt a presently owned home or to acquire or construct a home adapted with special features. Specially adapted housing (SAH) agents work in conjunction with the Veterans Service Center and the Veterans Health Administration (VHA) physicians to determine eligibility for an SAH grant and the feasibility of home adaptations.¹⁴ A veteran or an active-duty service member is eligible for SAH when he or she is entitled to compensation for a permanent and total service-connected disability that meets certain criteria.¹⁵ The maximum amount of money that a veteran can receive is \$50,000. A veteran can elect to use \$14,000 of this grant on alterations to a family member's home under the Temporary Residence Assistance Adaptation Program (TRAAP).

The following conditions meet the initial criteria for SAH eligibility:

- loss, or loss of use, of both lower extremities such as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair;
- blindness in both eyes, having light perception only, combined with the loss or loss of use of one lower extremity;
- loss or loss of use of one lower extremity together with residuals of organic disease or injury, which so affect the functions of balance or propulsion as to preclude locomotion without the aid of braces, crutches, canes, or a wheelchair; or
- loss, or loss of use, of both upper extremities such as to preclude use of the arms at or above the elbow.

There are other types of grants that certain service-connected veterans may be entitled to use for housing. The Home Improvement and Structural Alteration grant administered by VHA as a part of home health services is available in the amount of \$4,100 (a) for any service-connected disability, (b) for any disability of a veteran who has a service-connected disability at 50 percent or more, or (c) for the disability of a veteran who is actually in receipt of or entitled to receive disability compensation under the circumstances prescribed in 38 U.S.C. § 1710(a)(2)(C) and is available in the amount of \$1,200 to other veterans entitled to medical services under § 1710(a) (38 U.S.C. § 1717 [a][2] [2007]). This is a one-time benefit.¹⁶

Additionally, some veterans are eligible to receive special housing adaptation (SHA) grants. Specifically, SHA-eligible individuals are those who have blindness

¹⁴ VA, *M21-1MR*, 2A-8.

¹⁵ *Ibid.*, 3-2.

¹⁶ VA, *Federal Benefits for Veterans*, 9.

in both eyes with 5/200 visual acuity or less and/or anatomical loss or loss of use of both hands. The maximum amount is \$10,000. The same eligibility requirements are shared between the \$10,000 SHA grant and the Home Improvement and Structural Alteration grant. Of the SHA grant, \$2,000 can be used to alter a family member's home under TRAAP.

In 2006, VA spent \$25,780,000 on specially adapted housing, and expects these expenditures to rise to \$26,520,000 for FY 2008.¹⁷

In its 2004 publication *Evaluation of VA's Home Loan Guaranty Program*, Systems Flow, Inc. (SFI) concluded in 2004 that SAH is "a successful program that is exceeding its performance standard."¹⁸ The program was well received by the veterans participating in it: 94.3 percent of participating veterans stated that they were satisfied or very satisfied with the grant.¹⁹ However, at the time of the report, only 5.3 percent of eligible disabled veterans surveyed reported that they received information on the program.²⁰ Furthermore, the program failed to account for "the rising cost of construction [for it] is a leading factor as to why the maximum grant amount may not be sufficient in the future."²¹ To remedy this issue, the report recommended that VA "increase the maximum SAH amount based on annual increases in construction costs."²²

Current law does not extend this benefit to all service-connected burn injured veterans. In addition, this benefit does not take into account a veterans' need to relocate or allow his or her family to grow. A severely injured service member may need to temporarily live with a caregiver, but over time may gain more independence and be able to live alone. The TRAAP is a limited allowance capped at \$14,000 given for actual construction, equipment, and installation costs. Plus, it counts against the overall SAH grant. If the TRAAP allowance is used to modify transitional housing, then those funds would not be available for a more permanent residence.

Recommendation 6.4

The automotive and housing adaptation benefit should be modified to cover service-connected veterans who need this assistance and are not currently eligible—for example, severe burn victims.

¹⁷ VA, *Budget Summary*, 3A-14.

¹⁸ Systems Flow, *VA's Home Loan Guaranty*, 10-13.

¹⁹ *Ibid.*, 10-12.

²⁰ *Ibid.*, 10-14.

²¹ *Ibid.*, 10-13.

²² *Ibid.*, 10-13.

Recommendation 6.5

Provisions should be made to accommodate changing life circumstances by allowing a specially adapted housing grant at least twice.

II.5 Health Care

The Veterans Health Administration (VHA) delivers health care to service-connected disabled, poor, and other categories of veterans through its 21 Veterans Integrated Service Networks (VISN) that comprise 156 hospitals, more than 800 community-based outpatient clinics, 136 nursing homes, 43 residential facilities, and 209 Vet Centers. The number of unique patients treated has risen from 3.8 million in FY 2000 to 5.5 million in FY 2006. Of the 631,174 Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans who have left active duty and became eligible for VA since FY 2002, only 184,500 were treated by VA.^{23,24} There are over 7 million healthcare enrollees. The VA medical care and research funding obligation was over \$31.5 billion for FY 2006.²⁵

II.5.A VHA Priority Workload

Veterans are eligible to enroll in VA health care by priority group. These groups are:

1. Veterans with service-connected disabilities rated 50 percent or more disabling; veterans determined by VA to be unemployable due to these conditions
2. Veterans with service-connected disabilities rated 30 percent or 40 percent disabling
3. Veterans who are former prisoners of war; veterans awarded a Purple Heart medal; veterans whose discharge was for a disability that was incurred or aggravated in the line of duty; veterans with service-connected disabilities rated 10 percent or 20 percent disabling; veterans awarded special eligibility classification under 38 U.S.C. § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"
4. Veterans who are receiving aid and attendance or housebound allowances from VA; or have been determined by VA to be catastrophically disabled

²³ VA, *2006 Performance and Accountability*, 1–2.

²⁴ VHA, *VA Health Care Utilization*, 4.

²⁵ VA, *Organizational Briefing Book*, 3.

5. Non-service-connected veterans and noncompensable service-connected veterans rated 0 percent disabled whose annual income and net worth are below the VA established thresholds; veterans receiving VA pension benefits; veterans eligible for Medicaid programs
6. World War I veterans; Mexican Border Period veterans; compensable 0 percent service-connected veterans; veterans solely seeking care for disorders associated with: exposure to herbicides while serving in Vietnam, exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki, service in the gulf war, illness possibly related to participation in Project 112/SHAD; service in combat in a war after the gulf war or during a period of hostility after November 11, 1998, are eligible for VA health care for 2 years following discharge from military service for combat-related conditions
7. Veterans with income and/or net worth above the VA established threshold and income below the HUD geographic index who agree to pay copays: *Subpriority a*: Noncompensable 0 percent service-connected veterans who were enrolled in the VA health care system on a specified date and who have remained enrolled since that date; *Subpriority c*: Non-service-connected veterans who were enrolled in the VA health care system on a specified date and who have remained enrolled since that date; *Subpriority e*: Noncompensable 0 percent service-connected veterans not included in *subpriority a* above; *Subpriority g*: Non-service-connected veterans not included in *subpriority c* above
8. Veterans with income and/or net worth above the VA established threshold and the HUD geographic index who agree to pay copays: *Subpriority a*: Noncompensable 0 percent service-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date; *Subpriority c*: Non-service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date; *Subpriority e*: Noncompensable 0 percent service-connected veterans applying for enrollment after January 16, 2003; *Subpriority g*: Non-service-connected veterans applying for enrollment after January 16, 2003.²⁶

Veterans who would be assigned to priority groups 8e or 8g are not eligible for new enrollment as a result of a restriction that suspended enrolling new high-income veterans (with incomes above \$27,000) who apply for care after January 16, 2003. Veterans enrolled in priority groups 8a or 8c will remain enrolled and eligible for the full range of VA health care benefits.²⁷ Enrollment in VA health care therefore is not automatic for all separating service members. They must first make an application to the nearest VA facility where they will

²⁶ VA, *Enrollment Priority Groups*.

²⁷ *Ibid.*

relocate and have their eligibility determined. OIF/OEF veterans currently have 2 years of open enrollment.

Table 6.5 illustrates the workload distribution for service-connected and non-service-connected users of VA health care by priority group, and the associated cost of that care.

The reliance of service-connected veterans on VA health care increases from 42 percent for those 10–20 percent disabled, to 58 percent for those 30–40 percent disabled, to 83 percent for those 50–100 percent disabled. Overall, 59 percent of service-disabled veterans use VA health care. As might be expected, the cost of care increases with severity of disability from \$4,324 to \$4,678 to \$10,415 for those 10–20 percent, 30–40 percent, and 50–100 percent, respectively. The total cost of \$11.8 billion for health care for service-disabled veterans represents the largest benefit other than disability compensation. In spite of the higher cost per patient among the service-connected population, the majority of VA health care expenditures (57 percent) are on non-service-connected veterans. It is also noteworthy that the service-connected population makes up 33 percent of all patients treated, while the non-service-connected users represent 67 percent. This indicates a reliance on VA by other groups of veterans who are primarily indigent, and perhaps uninsured.

Currently, OIF/OEF veterans are eligible for VA health care for 2 years. Additionally, there is legislative activity to expand health care access for OIF/OEF veterans to 5 years after discharge. Financial stresses will continue to be placed on the system as it has to provide quality long-term care, mental health, and polytrauma rehabilitation to several generations of veterans with varying needs. When veterans are not able to obtain health care because of budget shortfalls and waiting lists then, “such veterans are at high risk for unemployment, homelessness, family violence, crime, alcoholism, and drug abuse, all of which impose an additional human and financial burden on the nation.”²⁸ VA is aware that the growing number of veterans seeking mental health care has highlighted an area in need of improvement. According to VA, there are clinics unable to provide this level of care or that have waiting lists that are making such services virtually inaccessible.

²⁸ Bilmes, *Soldiers Returning*, 13.

TABLE 6.5 VHA Priority Group Workload for FY 2006

PRIORITY GROUP	NUMBER OF ENROLLEES	NUMBER OF PATIENTS	TOTAL SERVICE CONNECTED	COST (\$000s)	MEAN COST	% OF TOTAL PATIENTS	% OF TOTAL COSTS	PATIENTS % OF SERVICE CONNECTED VETERANS
1. SC ^a 50% or more disabling	912,788	768,537	923,701	\$8,100	\$10,515	16	29	83
2. SC 30–40% disabling	522,829	342,023	594,765	\$1,600	\$4,678	7	6	58
3. SC 10–20%	879,965	495,272	1,193,067					
Subtotal SC	2,315,582	1,605,832	2,711,533	\$11,800	\$7,363	33	43	59
3. Non-SC patients in priority group 3	116,098	73,468		\$300	\$3,774	1	1	N/A
4. NSC ^b A&A, ^c housebound, & catastrophic	241,716	177,563		\$3,000	\$17,135	4	11	N/A
5. NSC means tested	2,538,228	1,575,645		\$9,000	\$5,669	32	32	N/A
6. WW I, GW, ^d SC 0% compensable	265,253	134,425		\$300	\$2,418	3	1	N/A
7. > VA means test but < HUD Geo	218,245	168,078		\$600	\$3,690	3	2	N/A
8. > VA means test & > HUD Geo	2,177,314	1,165,789		\$2,800	\$2,393	24	10	N/A
Subtotal NSC	5,556,854	3,294,968		\$16,000	\$4,852	67	57	N/A
Total	7,872,436	4,900,800		\$28,000	\$5,675			

SOURCE: VHA, 2006 Workload Data; Hessling, E-mail to Ray Wilburn.

^a SC = service connected.

^b NSC = nonservice connected.

^c A&A = aid and attendance.

^d GW = gulf war.

II.5.B Fee Basis Program

VA has provided service-connected disabled veterans with contracted care in their communities on a fee basis since 1945. VA is authorized to pay for inpatient, outpatient, prescription, and long-term care in non-VA facilities under 38 U.S.C. § 1703. VA will approve fee-basis care if VA does not provide the necessary level of treatment, or if a VA facility is too far from the veteran's home. For example, fee basis care could be authorized for chiropractic care, maternity care, or dialysis not otherwise available at a VA medical center. A veteran is eligible for inpatient or outpatient treatment on a fee basis when it is for the following:

- a service-connected disability;
- a disability for which the veteran was released from active duty;
- any disability of a veteran who has been rated permanently and totally disabled from a service-connected disability;
- a medical condition aggravating a service-connected condition;
- a disability and is participating in a rehabilitation program under 38 U.S.C., chapter 31;
- is in Alaska, Hawaii, and other U.S. Territories and needs care to prevent the need for hospital admission;
- is being provided a VA regional office observation and examination evaluation;
- is in authorized travel status and needs emergency care;
- is in a VA contract nursing home and needs emergency care; or
- is receiving care at a VA or other government facility on a VA contract and needs emergency treatment that the facility cannot provide.

Necessary outpatient treatment is also provided on a fee basis if a veteran is rated 50 percent or more disabled, needs to complete treatment begun at a VA medical facility, is a Mexican War or World War I veteran, needs aid and attendance, or is housebound. Other eligibility criteria include women who need inpatient care, prisoners of war who need outpatient dental services or who are being treated at an independent VA outpatient clinic and need diagnostic services to determine either eligibility for care or appropriate care to prevent the need for hospital admission.²⁹ In most cases, except urgent care, fee basis must be preauthorized and subject to the capabilities of the medical center so that the veteran does not incur any expenses.

²⁹ VA, *Fee Program*.

Although the Commission did not gather or analyze data on available funds, there appear to be inadequate funds to pay for fee basis care. Currently the Veteran Integrated Service Networks (VISNs) do not receive adequate funding for fee basis services. Therefore, medical providers refuse to service veterans fearing non-payment from VA. Congress should provide adequate dedicated funding to VA for fee basis care.

II.5.C Beneficiary Travel

VA is authorized under 38 USC §111 (g)(1) to pay certain service connected veterans rated 30 percent or greater or receiving VA pension beneficiary travel in order to receive medical care or exams. The reimbursement rate is 11 cents per mile or 17 cents per mile for a repeat Compensation and Pension exam. This rate is subject to a \$3.00 deductible for each one-way trip and is capped at \$18.00 per month.³⁰ This rate was set by Congress in 1978 and has not been increased since.

By comparison, the 2007 General Service Administration automobile mileage reimbursement rate for federal employees is as follows:

- 48.5 cents per mile (if no Government owned vehicle available)
- 28.5 cents per mile (if Government owned vehicle available)
- 12.5 cents per mile (if committed to use Government owned vehicle)
- 30.5 cents per mile motorcycle rate

Although VA recognizes this rate is substantially lower, it claims that paying veterans a higher travel rate would cut into its medical care budget. However, The DAV in 2006 noted that beneficiary travel reimbursements need to be sufficient to encourage disabled veterans to get the care that they need and not delay treatment because of travel expenses.³¹ DAV urged VA to “include a line item in its budget for the cost of increasing veterans’ beneficiary travel reimbursement rates to a more reasonable amount so that it can make the needed adjustment without reduction in funds for direct medical care to sick and disabled veterans.”³²

³⁰ Ibid., 6

³¹ Disabled American Veterans. *Resolution No. 212*.

³² Ibid.

II.6 Insurance

All service members are eligible to participate in Servicemembers Group Life Insurance (SGLI), and coverage up to \$400,000 is available at nominal premiums. Ninety-eight percent of service members elect to participate. The Commission observed that, while 98 percent is a high rate of participation, there is likely to be some number of service members who elect no coverage or too little coverage relative to their insurance needs, and some of those individuals may have dependents who can least afford to be without coverage.

In addition, three insurance programs are available for those with service-connected disabilities. In this section, the following insurance programs for service-connected veterans are discussed: Traumatic Servicemembers' Group Life Insurance (TSGLI), Service-Disabled Veterans' Insurance (SDVI), and Veterans' Mortgage Life Insurance (VMLI).

II.6.A Traumatic Servicemembers' Group Life Insurance

Traumatic Servicemembers Group Life Insurance (TSGLI) is a traumatic injury protection rider under Servicemembers' Group Life Insurance (SGLI) that provides for payment to any member of the uniformed services covered by SGLI who sustains a traumatic injury that results in certain specified severe losses. To be eligible for payment of TSGLI, service members must meet all of the following requirements:

- be insured under SGLI;
- incur a scheduled loss, and that loss must be a direct result of a traumatic injury;
- suffer the traumatic injury prior to midnight of the day that they separate from the uniformed services;
- suffer a scheduled loss within 730 days of the traumatic injury; and
- survive for a period of not less than 7 full days from the date of the traumatic injury.

Every member who has SGLI also has TSGLI effective December 1, 2005, and pays an additional premium of \$1 per month for TSGLI. All service members injured after December 1, 2005, and who have not opted out of SGLI, are eligible for coverage.

Congress directed that TSGLI would be retroactive to October 7, 2001, for members who were injured in OIF/OEF. This means that the member must have been deployed outside the continental United States on orders in support of OEF

or OIF or serving in a geographic location that qualified the service member for the combat zone tax exclusion under the Internal Revenue Service Code. This retroactive directive thus did not apply to those injured within the United States even though their injuries can be as extensive, require the same level of complex care, and incur the same burdens to service members and their families. In 2006, Congress revised the statute to require that injury occur “in theater of operations” for OIF/OEF on or after October 7, 2001, in order to qualify for retroactive TSGLI. However, VA has not yet issued regulations defining the term “theater of operations.”

The April 2007 Independent Review Group (IRG) report recommended that “The Secretary of Defense should review the TSGLI to ensure that coverage is extended to include the full spectrum of traumatic brain injury and posttraumatic stress disorder.”³³ This recommendation was based on the IRG findings that patients with TBI and PTSD were not getting the same level of benefits as other severely injured service members.

One of our government’s fundamental obligations is to provide for the needs of veterans arising out of their service to the Nation, but especially needs related to traumatic injuries from combat and other military service, which is inherently hazardous. With the brain injuries, amputations, and other serious trauma common in today’s Global War on Terror, disabled service members, disabled veterans, and the families of these injured warriors have an array of special needs that are a direct consequence of their serious, and often catastrophic, battlefield injuries. Those who undertake the dangerous task of fighting our country’s enemies should not have to do so at their own risk. They should not have to personally pay the costs to insure themselves against the perils of war and military service because that is unquestionably a part of the cost of war and national defense and therefore a primary government responsibility. The Traumatic Injury Protection now provided to service members as a rider to Servicemembers’ Group Life Insurance plans, for which service members are charged an additional premium, should be provided without cost to the service member.

There have been speculative and anecdotal reports about the use of TSGLI payments for everything from health care to home modifications to luxury items. Assessing the appropriateness of the benefit is difficult at this time, since no study has been conducted among recipients to ascertain how TSGLI payments have actually been spent.

³³ Independent Review Group, *Report*, 65.

Furthermore, neither VA nor DoD provide veterans or their families with financial planning assistance for managing this lump sum payment.

Recommendation 6.6

Eliminate the premium paid by service members for Traumatic Servicemembers' Group Life Insurance.

II.6.B Service-Disabled Veterans' Insurance

Service-Disabled Veterans' Insurance (SDVI) was created in 1951 to provide life insurance to disabled veterans who, because of their service-connected disabilities, would be unable to obtain life insurance on the commercial market or would be required to pay high premiums. A veteran who was discharged under other than dishonorable conditions and who has a service-connected disability, except for which the veteran would be insurable according to the standards of good health established by VA, may apply to VA within 2 years from the date service connection was granted for up to \$10,000 in life insurance coverage. Totally disabled veterans may apply for a waiver of premiums for the base policy and supplemental coverage of up to \$20,000.

Total SDVI policies are valued at \$1.4 billion. However, the rate of participation is only 3.5 percent for all veterans eligible. In 2001, the Systems Flow Inc. (SFI) *Program Evaluation of Benefits for Survivors of Veterans with Service-Connected Disabilities Report* found that the SDVI coverage amounts are not consistent with current individual insurance marketing offerings. The average face amount of life insurance policies purchased in 1999 was \$119,900.³⁴ SFI also found that the program "compares unfavorably to premiums in the private sector for healthy individuals."³⁵ Congress explicitly intended to have SDVI premiums hover close to the private sector's premiums for nondisabled individuals. To remedy the issues, the report details several recommendations for VA to "aggressively promote substantial increases in life insurance coverage for service-disabled veterans and lessen the barriers to coverage."³⁶

SDVI premiums were to be comparable to those commercial insurers charged healthy individuals. At the time of the legislation authorizing this program, 1941 mortality tables were in use, and the statute prescribed that premiums would be based on life expectancy as shown by the standard 1941 mortality tables. Because Congress has not amended this law to require use of modern mortality tables, premiums have become higher than those charged healthy persons.

³⁴ Systems Flow, *Program Evaluation of Benefits*, 4:121.

³⁵ Ibid.

³⁶ Ibid., 4:127.

Thus, the program no longer serves its intended purpose and has lost its effectiveness.

Recommendation 6.7

The maximum amount of coverage should be increased and up-to-date mortality rates should be used to calculate premiums for Service-Disabled Veterans' Insurance.

II.6.C Veterans' Mortgage Life Insurance

VMLI was authorized in 1971³⁷ to provide mortgage insurance to severely disabled veterans who would normally be unable to acquire insurance from private organizations. This benefit aims to compliment the SDVI by providing service-connected disabled veterans with the ability to provide for their beneficiaries' financial security. The benefit "provides up to \$90,000 in mortgage life insurance to recipients of VA's specially adapted housing grant to lessen the financial burden of surviving family members."³⁸

VMLI is available to veterans who receive a specially adapted housing grant. The premium a veteran must pay is derived from his or her age, the outstanding mortgage balance, and the remaining term of the mortgage. Termination of this benefit occurs when the veteran reaches his or her 70th birthday, or when the mortgage is paid in full, or ownership of the property is terminated, or the veteran requests a cancellation. This program has provided disabled veterans with the opportunity to care for their families and their own financial needs while securing appropriate housing.

The 2001 SFI evaluation of survivor benefits also evaluated the SDVI program. SFI concluded that it was basically meeting the expectations of Congress that it be available, affordable, and well received by the veterans participating in it. SFI found that, in terms of availability and affordability, the program "pays a premium cost that is significantly lower than the typical costs for a healthy individual in the private sector."³⁹ The participation rate was 65 percent.⁴⁰ Over 70 percent of VMLI participants reported that they were either satisfied or very satisfied with the program. Although the report is favorable on VMLI, SFI found that the program failed to cover significant mortgage amounts.

³⁷ Ibid., 4:141.

³⁸ Ibid., 9.

³⁹ Ibid., 4:59, section 2.

⁴⁰ Ibid., 59 section 2.

VMLI coverage also does not include service members of the Armed Forces who have received VA housing modification grants for severely disabling conditions. An expansion of this benefit would allow those on active duty to maintain the same level of coverage as veterans who have already transitioned.

Recommendation 6.8

Expand eligibility for the Veterans' Mortgage Life Insurance to include service members of the Armed Forces who have received housing modification grant assistance from VA for severely disabling conditions.

II.7 Veterans' Preference for Federal Employment

The Federal Government, since the end of the Civil War, has attempted to alleviate the economic cost associated with military service by providing favorable competitive positions within government employment to veterans.⁴¹ All federal jobs with the exception of the Senior Executive Service are open to preference.⁴²

According to the Office of Personnel Management (OPM), for entitlement to preference, a veteran must meet the eligibility requirements in 5 U.S.C. § 2108:

- The veteran must have received an honorable or general discharge.
- Military retirees at the rank of major, lieutenant commander, or higher are not eligible for preference unless they are disabled veterans.
- Guard and Reserve active duty for training purposes does not qualify for preference.

Preference is given to wartime or campaign veterans and certain survivors on a 5- and 10-point basis.

II.7.A 5-Point Preference

Five points are added to the passing examination score of a veteran who served

- during the period December 7, 1941, to July 1, 1955; or
- for more than 180 consecutive days, any part of which occurred after January 31, 1955, and before October 15, 1976; or

⁴¹ Office of Personnel Management, "Vets Info Guide."

⁴² Ibid.

- for more than 180 consecutive days, any part of which occurred during the period beginning September 11, 2001, and ending on the date prescribed by Presidential proclamation or by law as the last day of OIF; or during the gulf war from August 2, 1990, through January 2, 1992; or
- in a campaign or expedition for which a campaign medal has been authorized, including El Salvador, Grenada, Haiti, Lebanon, Panama, Somalia, Southwest Asia, Bosnia, and the Global War on Terrorism.

Gulf war veterans and those with the appropriate medals who enlisted after September 7, 1980, or entered active duty on or after October 14, 1982, must have served continuously for 24 months, or for the full period called or ordered to active duty to be eligible. The service requirement does not apply to veterans with compensable service-connected disabilities, or to veterans separated for disability in the line of duty, or for hardship.

II.7.B 10-Point Preference

Ten points are added to the passing examination score of a veteran who served at any time who

- has a present service-connected disability, or
- is receiving compensation, disability retirement benefits, or pension from the military or VA.
- Purple Heart recipients also qualify as disabled veterans.

The names of 10-point preference eligible veterans or family members, 5-point preference veterans, and nonveterans are listed in order of their numerical ratings. Entitlement to veterans' preference does not guarantee a job. There are many ways an agency can fill a vacancy other than by appointment from a list of certified applicants.⁴³ OPM has reported that veterans are currently holding 25 percent of all federal jobs.⁴⁴

II.8 Burial and Memorial Benefits

All veterans, with certain exceptions, discharged from active duty under other than dishonorable conditions and service members who die on active duty may be eligible for burial in a VA National Cemetery. Burial includes the gravesite, grave liner, opening and closing of the grave, a headstone or marker, and perpetual care. A funeral service includes an American flag and military honors.

⁴³ Office of Personnel Management, *Veterans Preference*.

⁴⁴ Office of Personnel Management, *Veterans Continue Entering Federal Employment*.

A claimant can be almost anyone if they paid for a veteran's burial or funeral in a private cemetery. In addition, the expenses were paid for a veteran who: (1) was discharged under conditions other than dishonorable; (2) died because of a service-related disability; (3) was receiving VA pension or compensation at the time of death; (4) was entitled to receive VA pension or compensation, but decided not to reduce his or her military retirement or disability pay; or (5) died in a VA hospital, nursing home under VA contract, or while in an approved state nursing home.⁴⁵

The following benefits are available to claimants: funeral allowance, burial plot allowance (\$300), transportation allowance (variable amount), a U.S. flag, a headstone or marker, a Presidential Memorial Certificate (if requested by the veteran's next of kin), and burial in a VA National Cemetery.⁴⁶ If the veteran dies from a service-connected disability, then the claimant is eligible to receive \$2,000 to offset the expenses of a funeral.⁴⁷

The headstone is provided without charge. This includes the expense of purchasing the appropriate headstone, engraving it, and sending it to any cemetery. If the claimant decides to bury the veteran in a private cemetery, the cost of placing the headstone will be borne by the claimant. However, a monetary benefit in lieu of a headstone or marker is available.

In 2006, VA spent \$141 million for the burial of 104,900 veterans, maintaining 2,922,180 graves, buying 344,900 headstones, and sending out 384,300 Presidential Memorial Certificates. VA expects these expenditures to rise to \$178,910,000 for FY 2008.

III Vocational Rehabilitation and Employment

The mission of the Vocational Rehabilitation and Employment (VR&E) Service is "to enable veterans with service-connected disabilities and employment handicaps to obtain and maintain suitable employment. When the severity of disability prohibits a veteran from maintaining suitable employment, VR&E assists them to achieve maximum independence in daily living."⁴⁸ Chapter 31 of 38 U.S.C. authorizes the VR&E program.

⁴⁵ VA, "Burial and Plot-Interment Allowances."

⁴⁶ New York State, "Burial Benefits."

⁴⁷ Garson, *Civil Service Reform Act*.

⁴⁸ Veterans Benefits Administration, *Annual Benefits*, 86.

The numbers of applicants to and participants in VR&E have risen significantly during the past 15 years, but the number of individuals who have been rehabilitated has remained constant. The number of applicants increased by 73 percent between FY 1992 and FY 2003 (from 37,829 to 65,298), and the number of participants increased by 67 percent during that period (from 58,155 to 97,158). Yet the number of individuals rehabilitated (as measured by obtaining a job or achieving independent living) has averaged only about 10,000 per year.⁴⁹

Table 6.6 shows statistics on VR&E applicants, participants, rehabilitated persons, and related data for FY 2006. Among participants that year, the majority (40,127) were gulf war era veterans.⁵⁰ Participants' most common age groups were between 30-39 years for males (10,037) and females (4,591).⁵¹ In descending order, the three most common percentage disability ratings for participants were 30 percent, 40 percent, and 20 percent.⁵²

Definitions for eligibility and entitlement are discussed in section III.2.A below.

Table 6.5 VR&E Activities, 2006

STATUS	TOTAL
Applicants	57,856
Denied eligibility	3,415
Denied entitlement	6,884
Entitled to services	36,513
Participants (subsistence recipients)	52,982
*Active cases	90,767
Rehabilitated (9,115 employed, 2,947 living independently)	12,062

SOURCE: Veterans Benefits Administration, Annual Benefits Report Fiscal Year 2006.

Washington, DC: VBA, 2007, unpublished; VA Office of Policy and Program Management.

*VBA Technical Review on the Veterans' Disability Benefits Commission Issue Paper.

Washington, DC: VA, 2007. 2.

⁴⁹ 2004 and 2005 Veterans Benefits Administration Annual Benefits reports

⁵⁰ Veterans Benefits Administration, *Annual Benefits*, 89.

⁵¹ *Ibid.*, 93.

⁵² *Ibid.*, 91.

III.1 VR&E History

The War Risk Insurance Act of 1914 was the precursor of vocational rehabilitation initiatives (Pub. Law 63-193, 38 Stat. 711 [1914]). In 1917, the War Risk Insurance Act Amendments provided for war veterans' rehabilitation and vocational training in cases of dismemberment, injuries to sight or hearing, and other injuries resulting in permanent disability (Pub. Law 65-90, 40 Stat. 398, 407. [1917]). VA's vocational rehabilitation programs further evolved after World War II, the Korean War, and the Vietnam War.

Since the mid-1980s, the organization and field structure of VR&E changed several times. Since 2000, these changes have been made to emphasize employment rather than education and training. Although education and training are significant components to rehabilitation, they are not the final outcome. Veterans who obtain degrees but not jobs, have not fulfilled their potential. Therefore, by highlighting employment, VA hopes to increase the number of veterans who find meaningful careers.

III.2 VR&E Program Description

VR&E is an integral part of the VA compensation package. It can be pivotal to helping separating service members transition into the civilian work force. During the Transition Assistance Program (TAP) or Disabled TAP (DTAP) briefings, separating service members are informed about VR&E.

III.2.A Eligibility and Participation

There are several requirements that individuals must meet to become eligible for participation in VR&E. First, active-duty service members awaiting discharge due to a disability and veterans who have a compensable disability incurred after September 15, 1940, are eligible to apply for VR&E for up to 12 years from the date when VA granted service connection. Entitlement is established if the veteran is rated at 20 percent or more with an employment handicap or is rated at 10 percent with a serious employment handicap. As defined by VR&E, an employment handicap is an impairment of the individual veteran's ability to prepare for, obtain, or retain employment consistent with his or her abilities, aptitudes, and interests. A vocational rehabilitation counselor/counseling psychologist (VRC/CP) makes the entitlement determination based on a comprehensive evaluation, which includes assessments of the veteran's interests and abilities and the extent of impairment.⁵³ A veteran can be found eligible and entitled but still be denied services if the counselor determines that rehabilitation

⁵³ VR&E Task Force, *Report to the Secretary*, 45–46.

is unachievable or unnecessary. If the veteran is granted services, the VRC/CP and the veteran develop a plan that specifies an employment or independent-living goal and outlines the services and resources needed to achieve it. VR&E has five established tracks to recovery, as illustrated in Table 6.6.

If a veteran is not entitled to VR&E services, the VRC/CP will refer the veteran to other resources, such as state vocational rehabilitation programs, the Department of Labor (DOL), small business advisors, Internet-based resources, student financial aid information, or a combination thereof. Although VR&E does not train veterans to serve as volunteers, many severely injured veterans—such as those with TBI who are unemployable—have the potential to act as volunteers given the training and assistance to adjust to new environments and activities.

Age is not a factor in determining eligibility or entitlement to VR&E services. Table 6.7 illustrates the age distribution of male participants in VR&E in FY 2005.⁵⁴ More than 1,000 veterans over age 60 participated in the program that year. According to the *Older Americans Update 2006*, the percentage of Americans 65 years and older in the workforce has increased. This trend is not merely due to financial necessity. Older Americans today are more functional now than in the past. They desire social contact, intellectual challenge, and the sense of worth that comes from working.⁵⁵ Employment serves many purposes at any age.

⁵⁴ Veterans Benefits Administration, *Annual Benefits*, 88.

⁵⁵ Forum on Aging-Related Statistics, *Older Americans Update 2006*, 18–19.

Table 6.6 VR&E Five Tracks to Employment

REEMPLOYMENT	RAPID ACCESS	LONG TERM	INDEPENDENT LIVING	SELF-EMPLOYMENT
Return to former civilian job	DOL Realifelines	On-the-job training	In-home assessment	No traditional employment
Uniformed Services Employment and Reemployment Rights Act (USERRA), 1994	Army Material Command	Apprenticeships	Assistive technology	Flexible schedule
	DOD support programs	Internships	Independent-living skills training	Accommodating work environment
	VA Coming Home to Work	Job shadowing	Community support programs	Funding for start-up supplies, etc.
	Military Severely Injured Center	Higher education (tuition, books, etc.)	Referrals: medical, dental, eye, etc.	Assistive technology
	Helmets to Hardhats			
	Private-sector initiatives			

SOURCE: Vocational Rehabilitation and Employment Task Force. Report to the Secretary of Veterans Affairs: The Vocational Rehabilitation and Employment Program for the 21st Century Veteran, Washington, DC: VA, 2004, 45–46.

Table 6.7 Age Distribution of Male Participants in VR&E, FY 2006

AGE GROUP (YEARS)	NO. PARTICIPATING IN VR&E
22-29	8,366
30-39	10,037
40-44	7,751
45-49	6,749
55-59	5,914
≥ 60	3,907

SOURCE: Veterans Benefits Administration. Annual Benefits Report Fiscal Year 2006. Washington, DC: VA, 2006, unpublished.

III.2.B Services

VR&E services include

- evaluation to determine abilities, skills, interests, and needs;
- vocational counseling and rehabilitation planning;
- job-seeking services, resume development, and work readiness assistance;
- assistance finding and keeping a job, including special employer incentives;
- on-the-job training, apprenticeships, and nonpaid work experiences;
- postsecondary training at a college or a vocational, technical, or business school;
- supportive services, including case management, counseling, and referral;
- self-employment assistance; and
- independent living services.

III.3 VR&E Program Reviews and Evaluations

The Commission reviewed the following VR&E evaluations:

- The Congressional Commission on Servicemembers and Veterans Transition Assistance, completed in January 1999
- The Vocational Rehabilitation and Employment Program for the 21st Century Veteran, completed in March 2004
- VBA's Outcome-Based Assessment of the VR&E Chapter 31 Program, completed in June 2005 by independent auditor Dr. David Dean
- GAO Report: VA Should Improve Its Management of Individual Unemployability (IU) Benefits by Strengthening Criteria, Guidance, and Procedures, completed in May 2006
- GAO Report: Vocational Rehabilitation: VA Has Opportunities to Improve Services, but Faces Significant Challenges, completed in April 2005
- President's Commission on Care for America's Returning Wounded Warriors, completed in July 2007
- Veterans' Disability Benefits Commission Site Visit Final Report, completed in October 2006

According to these sources, VR&E has made significant steps toward improving outcomes, yet VA could undertake new initiatives to further improve the program.

A number of findings and recommendations in these reports resonated with the Commission, and they are summarized below.

III.3.A VA Task Force on VR&E

The 2004 VA Task Force on Vocational Rehabilitation and Employment conducted a comprehensive review of the program and compiled 110 recommendations. Among them, the Task Force cited:

- Limited data and analysis to effectively manage the program
- Low success rates and a high attrition rate of program participants
- Poor planning and implementation of improvement projects
- Need for a more aggressive and proactive approach to serving veterans with serious employment handicaps
- Lack of comprehensive rehabilitative services

The recommendations made by the Task Force stem from two objectives: first, VR&E should place priority on disabled veterans who have the most serious disabilities that impact quality of life and employment; and second, the system should eliminate the need for service connection as a prerequisite for receiving VR&E services. The second objective would allow as many disabled veterans as possible to receive services. This would be especially valuable to transitioning service members who are found unfit for duty and to veterans who are 50 percent disabled and receiving special monthly compensation for the loss of a limb or loss of use of a limb.⁵⁶ The Task Force also recommended that service members found unfit for duty and medically discharged from the military be automatically entitled to VR&E services so that they can make informed choices about their future.⁵⁷ In addition, the Task Force recommended the removal of the time limit for applying for VR&E services so that any veteran could seek VR&E counseling at any time.⁵⁸ A significant number of veterans have never filed a disability claim but would benefit from educational or vocational counseling.⁵⁹

III.3.B GAO Reports

In 2005, GAO reported on VR&E operations and the Task Force report. GAO generally agreed with the Task Force's three key findings, which were the following:

⁵⁶ VR&E Task Force, *Report to the Secretary*, 81.

⁵⁷ *Ibid.*

⁵⁸ *Ibid.*

⁵⁹ *Ibid.*, 80.

1. VR&E has not been a VA priority in returning disabled veterans to the workforce.
2. VR&E has a limited capacity to manage its growing workload.
3. VR&E must be redesigned for the modern employment environment.

GAO questioned the validity of VA's practice of basing disability decisions exclusively on medical conditions.⁶⁰ Medical conditions alone are generally poor predictors of work incapacity, because advances in prosthetics and assistive technologies enable many people to compensate for certain impairments in the workplace. In addition, GAO supported the Task Force's finding that, "VR&E should provide more complete vocational assessments to assist in disability and vocational decisions...specifically, perform a functional capacity evaluation that would identify what work a veteran could do in the paid economy despite his or her disabilities."⁶¹ GAO further saw this as a valuable role for VR&E in assisting with Individual Unemployability (IU) determinations. (No such assessment is currently required or authorized.) However, before veterans are deemed unemployable, GAO believes that VR&E counselors who are experts in this area should assess that there are no other services that could benefit these veterans in their ability to sustain gainful employment. As of FY 2005, more than 219,000 veterans were collecting IU,⁶² but VR&E had evaluated only 495 of those cases.⁶³

III.3.C President's Commission on Care for America's Returning Wounded Warriors

The President's Commission on Care for America's Returning Wounded Warriors presented its six recommendations to the President in July 2007, which included two suggestions for encouraging the completion of VR&E training. The first action step would "allow veterans to suspend training for a time or attend part-time (for up to 72-months), with approval."⁶⁴ The second suggestion calls for VA to "pay a bonus of 10 percent of annual transition pay as described by the commission for completing the first and second years of training and a 5 percent [bonus] for completing the third year,"⁶⁵ amounting to a potential 25 percent bonus in total.

⁶⁰ GAO, *VA Should Improve*, 11.

⁶¹ *Ibid.*, 12.

⁶² *Ibid.*, 10.

⁶³ Steier, *Vocational Rehabilitation*.

⁶⁴ America's Returning Wounded, *Report*, 7.

⁶⁵ *Ibid.*

III.4 VR&E Staffing Issues

VA's performance goal is that each counselor or case manager have no more than 125 cases at a time. As of August 2006, however, the 621 VR&E case managers were managing an average of 146 veterans.⁶⁶

The Commission found that specialists employed in the DOL Disabled Veterans' Outreach Program (DVOP) carry an average case load of 50 veterans. The states' Departments of Rehabilitation Services suggest that an average caseload be between 80 and 100 people with disabilities actively seeking employment.⁶⁷ The Army Wounded Warrior program has assigned one family management specialist a caseload of 40 service members to best maximize rehabilitation and transition capabilities.⁶⁸ The VR&E Task Force recommended that VBA add more than 200 new employees to the workforce.

III.5 Satisfaction Reporting

VR&E does not conduct formal customer-satisfaction surveys of employers to assess the services rendered during the rehabilitation process. Therefore, feedback was solicited from the Disabled American Veterans (DAV), which is a major participant in the on-the-job training program to train their new national service officers (NSO). DAV described its members' experiences with VR&E as very successful and a great tool for training new NSOs.⁶⁹ However, DAV also saw the need for VR&E case workers to follow-up with participants on a regular basis, especially when participants are struggling and at risk of failure. Case workers tended not to intercede except when veterans needed specialized equipment. DAV also suggested that satisfaction surveys be conducted to obtain veterans' feedback on the usefulness of the program.

Additionally, the Commission itself tried, for over eight months, to create an opportunity for any veteran interested in a Nonpaid Work Experience Program placement to join the Commission's staff. The process was time consuming, confusing (with multiple contacts to four different VR&E staff members within the central office and the regional offices, and fraught with misinformation). The process produced results only after a veteran interested in interning with the Commission came forward, and after several more weeks of phone calls were made to facilitate the process. The veteran unfortunately had to leave the internship when he could no longer afford the out-of-pocket expense of

⁶⁶ Policy and Program Management, *VBA Technical Review*, 2.

⁶⁷ Garrick, *Site Visit Summary*.

⁶⁸ Carstensen, Veterans' Disability Benefits Commission.

⁶⁹ Austin, Veterans' Disability Benefits Commission.

participating. In this case, increased contact with a VR&E counselor and a review of the plan might have facilitated a more successful outcome.

III.6 Findings

The mission of VR&E is to help veterans with service-connected disabilities to prepare for, find, and maintain suitable jobs. For veterans with service-connected disabilities so severe that they cannot immediately consider work, VR&E offers services to improve veterans' abilities to live as independently as possible. Repeated efforts at program reform throughout the years have met with varying degrees of success.

In considering whether age should be a factor for VR&E, there was evidence that older Americans are involved in competitive employment. Therefore, older, employment-seeking veterans may still need vocational rehabilitation. There is no evidence to support an age limitation.

The VR&E program needs additional case managers to achieve its performance goal of 125 program participants for each case manager.

The Commission agrees with GAO's conclusion that VR&E should screen IU claimants for employability.

The Commission largely agrees with the VR&E Task Force's recommendation to expand eligibility for VR&E counseling to all service-disabled veterans seeking suitable employment and to make any service member found unfit for duty and medically separated from the military automatically entitled to VR&E.⁷⁰ The Task Force also found that all service-disabled veterans should be able to receive VR&E counseling services to help them identify career paths and further determine their eligibility and entitlement to VR&E services.⁷¹

VR&E needs to improve its process of defining, tracking, and reporting on participants, which is confusing and inconclusive in its current state. Intended program outcomes need to be measured beyond 60 days to ensure long-term success among veterans with service-connected disabilities. Additionally, employers and veterans should be surveyed to ascertain customer satisfaction and understand gaps in the program.

⁷⁰ VR&E Task Force, *Report to the Secretary*, 81.

⁷¹ *Ibid.*, 96.

The Commission believes that the goal of disability benefits as expressed in Guiding Principle Two, is not being met. In spite of the studies done and recommendations made in recent years, VR&E is not accomplishing its primary goal. The Commission believes that recent studies have provided the necessary analysis and that the VA possesses the necessary expertise to remedy this failure. Simply put, VA must develop specific plans and Congress must provide the resources to quickly elevate the performance of VR&E.

Based on these finding, the Commission makes the following recommendations:

Recommendation 6.9

Access to vocational rehabilitation should be expanded to all medically separated service members.

Recommendation 6.10

All service disabled veterans should have access to vocational rehabilitation and employment counseling services.

Recommendation 6.11

All applicants for Individual Unemployability should be screened for employability by vocational rehabilitation and employment counselors.

Recommendation 6.12

The administration of the Vocational Rehabilitation and Employment Program should be enhanced by increased staffing and resources, tracking employment success beyond 60 days, and conducting satisfaction surveys of participants and employers.

Recommendation 6.13

VA should explore incentives that would encourage disabled veterans to complete their rehabilitation plan.

IV Concurrent Receipt

IV.1 Issue

In the context of veterans' benefits, the term *concurrent receipt* refers to the simultaneous receipt of military retirement benefits from DoD and disability compensation benefits from VA. Concurrent receipt was banned by statute from 1890 to 1999 based on the logic that to receive both payments would mean paying twice for the same military service.

Disability compensation is designed to compensate individuals for the "average impairments of earning capacity" resulting from the disability (38 U.S.C. § 1155 [2006]). Military longevity retirement benefits, on the other hand, are granted to service members based on time served and generally require a minimum of 20 years in service. Alternatively, if an individual is forced to leave the service because he or she is found unfit for duty as a result of a service-connected disability, the person may be eligible to receive military *disability* retirement benefits or separation pay, depending on his or her length of service and disability rating. Military disability retirement benefits are distinct from VA disability compensation.

The historical ban on concurrent receipt required military retirees who were also eligible for VA disability compensation to offset, or reduce, part of their military retirement benefit payments and all of their separation pay equal to the amount of money they receive in VA disability compensation. In 2002, this offset amounted to a \$3.6 billion savings for DoD.⁷²

Although disability compensation has been offered to injured service members since colonial times, the United States did not introduce military longevity retirement benefits until 1861. The first legislation prohibiting concurrent receipt was enacted in 1890 with the reasoning that military longevity retirement benefits "[are] intended to be [compensation] in full for all military services" (21 Cong. Rec. 8510-8511 [1890]). Fifty years later, Congress enacted legislation that allowed retirees to waive a portion of their military longevity retirement benefits to receive VA disability compensation. Many military retirees who qualify for disability compensation choose to receive it because it is tax free and because electing it makes veterans eligible for other VA services and benefits, including priority care in the VA health care system.

⁷² Dye, *Prohibition on Concurrent Receipt*, 6.

Since 1999, Congress has moved towards allowing concurrent receipt, primarily through the implementation of three new benefits. The first, Special Compensation for Severely Disabled Military Retirees (SDMP), was created for veterans with at least 20 years of military service and a service-connected disability rated at 70 percent or higher and who applied for the benefit within 4 years of discharge. Congress specified that SDMP, which was in effect from 1999 to 2003, was "not retirement pay," and therefore could not be offset by VA disability compensation (The National Defense Authorization Act for Fiscal Year 2000. Pub. L. No. 106-65, § 658, 113 Stat. 518, 1999). The benefit (paid by DoD) ranged from \$100 to \$300 per month, depending on the individual's disability rating. In 2002, Congress lowered the threshold for SDMP eligibility from a 70 percent disability rating to 60 percent.⁷³

In another move toward concurrent receipt for disabled veterans, Congress created a tax-free compensation in 2002 called Combat-Related Special Compensation (CRSC). Currently, CRSC grants full concurrent receipt to any veteran with 20 years or more on active duty and rated from 10 percent through 100 percent, regardless of Purple Heart status.

Further, to enable qualified disabled military retirees to receive both their full military retirement pay and their VA disability compensation, Congress in 2003 added provisions that have come to be known as Concurrent Retirement and Disability Pay (CRDP) (*The National Defense Authorization Act for Fiscal Year 2004*. Pub. L. No. 108-136, § 641, 117 Stat. 1392, 2003). Paid by DoD, CRDP incorporated SDMP and was designed to be phased in over 10 years. In the first year, the veteran's monthly CRDP payment was equivalent to the amount specified by the veteran's disability rating. In the second year, the CRDP payment was increased by 10 percent of the amount of the veteran's military retirement pay that had been offset (reduced) by VA compensation. In each succeeding year, the CRDP payment was and will be increased by 10 percent of the offset. By this method, qualified retirees will receive their full military retirement pay and disability compensation by 2014.

The Temporary Early Retirement Authority (TERA) program in the 1990s allowed mostly officers to retire early on reduced retirement. TERA retirees are those who retired from DoD who had from at least 15 years but less fewer than 20 years of service. These individuals are eligible for CRDP at a reduced rate based on the number of years they had served when they retired. If they worked as a teacher or police officer immediately after retiring, they could add enough years to receive a regular 20-year retirement from DoD.

⁷³ Ibid., 8.

Congress eliminated the 10-year CDRP phase-in period in 2004 for veterans with disability ratings of 100 percent, granting those individuals full and immediate concurrent receipt. Finally, in 2006, Congress reduced the phase-in period to 5 years for those veterans who qualify for Individual Unemployability (IU) and therefore receive disability compensation at the 100 percent rating level (*The National Defense Authorization Act for Fiscal Year 2004*, Pub. L. No. 108-136, § 641, 117 Stat. 1392, 2003).

The arguments surrounding veterans' concurrent receipt concern what level of disability and what length of service should permit concurrent receipt to a military retiree or a service member whose career is shortened due to disability. Those in favor of concurrent receipt argue that DoD retirement benefits (and separation pay) and VA disability compensation have different stated purposes; therefore, they do not represent dual compensation. These proponents state that DoD retirement benefits and separation pay are disbursed to compensate veterans for their years of service to the country, while VA disability compensation is paid to help offset the adverse effects of a service-connected injury or illness on the veteran's ability to earn a living. By contrast, those opposed to concurrent receipt argue that retirement benefits and disability compensation represent duplicate payments for the same period of service. These opponents further argue that the cost of such duplicate payments is too high for the military and would not lead to any discernable increase in recruitment or retention rates.

At present, concurrent receipt is available to retirees who are receiving military retirement benefits based on 20 or more years of service and who have a VA disability rating of at least 50 percent. After waiving the equivalent part of their retirement pay to receive the disability benefits, these retirees may be qualified for both CRDP and CRSC. However, retirees who are eligible for payments from both programs may receive payments from only one of them, which must be selected annually.

Under current law, so-called Chapter 61 retirees are not eligible for concurrent receipt. Chapter 61 individuals are veterans whose service-connected disabilities forced them to retire from the military before they completed 20 years of service. The military disability retirement benefits of Chapter 61 retirees are payment for a reduced quality of life, loss of function, and decreased future earnings.

IV.2 Findings

The Commission finds that the purposes of military retirement programs and VA compensation programs are distinct, so one cannot be treated as a substitute for

the other. The Commission also finds that Chapter 61 disability retirees and separations should be eligible for concurrent receipt.

The Commission is particularly concerned about disabled junior enlisted service members. Given that many Commissioners served in the infantry, they know that the majority of severely injured service members are younger than age 30. The Commission is also concerned about service members who receive only a lump sum disability severance payment because their disabilities have been evaluated as less than 30 percent by the services, particularly the Army. Moreover, that lump sum payment is recouped by VA as though it were a disability payment.

The Commission concludes that all retirees and those separated due to disability should receive DoD retirement or separation pay as well as VA disability payments. Because of disability and a shortened military career, those separated or retired under Chapter 61, those with combat disabilities, and those with more severe disabilities should be given priority for concurrent receipt.

Recommendation 6.14

Congress should eliminate the ban on concurrent receipt for all military retirees and for all service members who separated from the military because of service-connected disabilities. In the future, priority should be given to veterans who separated or retired from the military under chapter 61 with

- **fewer than 20 years service and a service-connected disability rating greater than 50 percent, or**
- **disability as a result of combat.**

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Appropriateness of the Level of Benefits

In this chapter, the Commission analyzes the appropriateness of the level of benefits available to veterans for disabilities and deaths attributable to military service. The benefits themselves and their appropriateness were described in chapter 6.

I Impairments of Earning Capacity

The Department of Veterans Affairs (VA) Schedule for Rating Disabilities (VASRD) is intended to compensate for average impairment of earning capacity as required by statute.¹ That is to say that impairment is not specifically linked to an individual veteran, his or her skill set, and the ways a particular injury or disease affects that individual's ability to maintain gainful employment. For instance, the Rating Schedule does not take into account the difference between a lawyer losing a leg and a carpenter suffering the same loss; the two individuals are rated equally, even though an argument could be made that the amputation of a leg compromises a carpenter's ability to earn a livelihood more than a lawyer's ability to do so.

The Rating Schedule should not only be up to date medically, in terms of diagnostic classifications, terminology, and types of required tests and examinations, but should also be effective in fulfilling the purposes of the VA Disability Compensation Program. The stated statutory purpose is to compensate for average impairments of earning capacity. Another, unstated purpose of at least some aspects of the disability compensation program is to compensate for loss of quality of life. This Commission asked the Institute of Medicine (IOM) Committee on Medical Evaluation of Veterans for Disability Compensation to assess the ability of the Rating Schedule to compensate for impairment of earning capacity, loss of quality of life, or both. The Commission also asked the CNA Corporation (CNAC) to analyze average earnings of beneficiaries by rating percentage in each of the body systems and in cases of posttraumatic stress disorder (PTSD) specifically, and to survey veterans about

¹ President's Commission, *Administration of Veterans' Benefits*, 33.

their quality of life. This section of the report reviews the work of IOM and CNAC and presents the Commission's findings on the effectiveness of the Rating Schedule in compensating for average impairments of earning capacity and loss of quality of life.

I.1 Compensating for Impairments of Earning Capacity

Because average impairments of earning capacity are the basis of the VA Rating Schedule, it is important to understand the concept in the context of the VA Disability Compensation Program. According to the report of the IOM Committee on Medical Evaluation of Veterans for Disability Compensation, impairment of earning capacity "is more a legal or economic than medical concept":

It is used in the legal system as a basis for determining damages in personal injury cases. It was carried over into workers' compensation programs, which were established in the early 20th century to replace the tort system in dealing with accidents at work. When disability benefits for veterans were established by an amendment of the War Risk Insurance Program in 1917, the concept of a rating schedule to compensate for diminished earning capacity was borrowed from state workers' compensation programs.²

I.2 Impairments of Earning Capacity in Court Cases

In most courts, earning capacity is the standard for assessing economic damages due to loss of wages or salary caused by injury or death rather than a standard of actual or expected earnings.³ According to a recent treatise on the law of damages, the law typically defines earning capacity as "the ability to earn money" and impairment of earning capacity as "the diminution or loss of the ability to earn money."⁴ A recent manual on determining earning capacity has the following definition: "Earning capacity measures a person's past, present, and future ability to earn employment income with respect to their maximum ability."⁵

The concept of impairment of earning capacity was developed because it was commonly recognized that actual earnings before a person is injured are not an adequate measure of the impact of a person's disability. One example of a situation in which pre-injury earnings would not reflect a person's maximum ability to earn is when someone is too young to have an earnings record or, if they have one, it would not accurately reflect the ramp up of experience and

² Institute of Medicine (IOM), *21st Century System*, 64.

³ Horner and Slesnick, "Valuation of Earning Capacity Definition," 13-32, at 13.

⁴ Minzer et al., *Damages in Tort Actions*, 31.

⁵ Shahnasarian, *Assessment of Earning Capacity*.

skills—and therefore the increase in earning potential—of someone in the early- and midcareer phases of their working life. This situation is especially pertinent to veterans' compensation because, for many service members, the military is their first real job.

Although the courts recognize the concept of impairment of earning capacity, they have fairly strict evidentiary requirements that require plaintiffs to have more than a speculative basis for the damages suffered in earning capacity that they are claiming. Generally, a plaintiff's estimate of impaired earning capacity must be based on reasonable certainty, although courts do not usually require absolute precision. As a result, the plaintiff's history of earnings, or forecast of expected earnings based on past earnings, often has a large influence on court decisions:

Often, the most reliable evidence will be past earnings, which is also the most common basis for estimating expected earnings. In other words, the legal standard of loss in personal injury cases is usually earning capacity, but the evidentiary requirements of the legal process often lead to an estimation of earning capacity that is identical to an estimation of expected earnings.⁶

The assessment of earning capacity considers the person's medical situation in conjunction with vocational factors:

Assessing earning capacity involves a complex, systematic process to determine the maximum amount of employment income an individual is capable of generating, given her or his vocational profile, workplace conditions, specified industry or locale, and other relevant factors. The process may involve reviewing records to determine demonstrated and potential capabilities, interviewing the claimant, administering standardized tests to the claimant, and conducting labor market research.⁷

Typically, a vocational expert analyzes variables including age, education, work history, and local labor market conditions, as well as income at the time of injury.⁸ The expert looks at the physical and mental limitations reported by the physician; psychological issues affecting career development; education and training; work history, experience, and skills; age; vocational handicaps; and capacity for retraining. This usually involves a clinical interview and appropriate tests. The expert next determines a vocational category or categories that would maximize the individual's earnings both before and after the injury. Finally, the vocational expert conducts a labor market analysis to further understand the demand and

⁶ Horner and Slesnick, "Valuation of Earning Capacity Definition," 13-32, at 13.

⁷ Shahnasarian, *Assessment of Earning Capacity*.

⁸ Field, *Strategies for the Rehabilitation Consultant*.

prevailing wages for the individual's vocational category and to determine the likely loss of earnings.⁹

I.3 Impairments of Earning Capacity in Workers' Compensation Program

Beginning in 1911, when state workers' compensation programs were being established, the concept of impairment of earning capacity was included, sometimes expressed as loss of ability to compete in the labor market, although at first most used actual wage loss as the basis for compensation.¹⁰ New Jersey, one of the first 10 states to establish a workers' compensation program in 1911, included a schedule to determine compensation, which was an innovation. According to the schedule, the injured worker was paid half his or her wages for a fixed number of weeks, depending on the injury and its extent, even though the statutory basis for compensation in New Jersey was impairment of earning capacity. For example, if a New Jersey citizen lost a hand at work, he or she was paid 50 percent of his or her wages for 150 weeks. This was criticized at the time as opposed to the principle of compensation for permanent partial disability (i.e., it should be paid in proportion to the reduction in earning capacity as long as the disability lasts), but almost every state soon adopted schedules as more administratively convenient and more predictable in terms of benefit costs. It saved a program from having to evaluate the individual earning capacity of injured workers, which depended on the type and severity of their injury but also on their age, education, work experience, and local labor market conditions. This simplified the process by assigning a fixed amount or number of weeks to a given loss or functional limitation of a body part or system, without regard to actual loss of earnings.

Another problem facing the early workers' compensation programs and the veterans' disability compensation program was lack of knowledge of the effect of injury on employability or earnings.

The introduction of workmen's compensation into this country was too hasty and precipitate to permit of the immediate preparation of the necessary statistical material on which to base economically sound schedules of awards....The consequence has been a very great and unscientific diversity among the provisions of our state laws.¹¹

Currently, state workers' compensation programs use one or a combination of the following approaches:¹²

⁹ Shahnasarian, *Assessment of Earning Capacity*.

¹⁰ Larson and Larson, *Larson's Workers' Compensation*, § 80.05[3].

¹¹ Van Doren, *Workmen's Compensation and Insurance*, 109.

¹² National Academy of Social Insurance, *Adequacy of Earnings Replacement*, 13.

1. Compensation for degree of impairment: “The level of impairment, often expressed as a percentage of full functionality or ‘whole body,’ is sometimes translated into a percentage of total disability. This percentage is then used to determine the benefit amount.”
2. Compensation for impairment of earning capacity: “Some states modify the impairment rating to try and account for impairment of earning capacity by adjusting for vocational factors, such as the worker’s education, job experience, and age.”
3. Compensation for actual lost wages: “Other states employ a system that attempts to compensate workers for actual lost wages.”

Most state workers’ compensation programs, even those with a statutory mandate to compensate for impairment of earning capacity, use a rating schedule based mostly, if not completely, on degree of impairment.

I.4 Impairments of Earning Capacity in Veterans’ Disability Compensation

The War Risk Insurance Act of 1917, which authorized disability compensation for veterans, was drafted by social insurance experts involved in designing state workers’ compensation programs. The idea of compensating for the percentage of impairment of earning capacity and using a rating schedule to determine the percentage was taken from the recently established state workers’ compensation programs, but the VA Rating Schedule differed from the state programs in important ways. As a result, in many ways it was truer to the underlying principles of workers’ compensation than most of the state programs. These underlying principles include

- monthly payments compensating for the degree of impairment of earning capacity as long as the disability lasts (rather than paying a flat rate, usually two-thirds of wages, for a fixed number of weeks),
- compensating for diseases, including mental disorders, as well as physical injuries (rather than just compensating for physical injuries),
- compensating for all disabling conditions (rather than a delimited schedule of specific conditions),
- making everyone eligible for the benefit (rather than excluding certain employment groups), and
- adjusting the payments for family size (rather than paying the same amount regardless of the number of dependents).

The veterans' compensation program also diverged from underlying principles in several ways, for example, by:

- paying benefits for life (rather than just during time the individual is expected to work),
- paying the same amount to all veterans (rather than adjusting for individual differences in wages,
- not paying for injuries resulting from a veteran's "willful misconduct" (rather than being fully no-fault, though in practice, most state workers' compensation programs also bar compensation for injuries caused by willful misconduct), and
- paying the full extent of impairment earning capacity (rather than paying a fraction of wages; state programs paid a fraction to provide an incentive for workers to return to work.

Section 300 of the act provided compensation for death or disability resulting from personal injury suffered or disease contracted in the line of duty by active-duty service members and Army and Navy nurses. It specified that compensation for total disability would be between \$30 a month (for a single veteran) to \$75 a month (for a veteran with a wife and three or more children). Compensation for partial disability was set as a percentage of the compensation amount for total disability, "equal to the degree of the reduction in earning capacity resulting from the disability."

To implement the scheme for rating partial disabilities, section 302(2) of the act directed the Bureau of War Risk Insurance to adopt a "schedule of ratings of reductions in earning capacity from specific injuries or combinations of injuries of a permanent nature," with ratings up to 100 percent.

The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations and not upon the impairment in earning capacity in each individual case, so that there shall be no reduction in the rate of compensation for individual success in overcoming the handicap of a permanent injury.

Before the first Rating Schedule was completed, the law was amended by adding a sentence to the paragraph just quoted:

The Bureau in adopting the schedule of ratings of reduction in earning capacity shall consider the impairment in ability to secure employment which results from such injuries (Ch. 104, part 10, 40 Stat. 609, 611[1919]).

The federal program had the same problem in assigning percentages of impairment of earning capacity to a particular injury or disease or severity of injury or disease as the state workers' compensation programs did, namely, lack of relevant data. The Bureau of War Risk Insurance proceeded nevertheless by establishing an advisory board of three members "skilled in the practice of insurance against death or disability," who consulted with other experts and drew on the experience of other programs, including state workers' compensation programs and foreign veterans' compensation programs, to construct the first schedule for rating disabilities (Pub. L. No. 65-90, Art. I, § 14, [1917]).¹³ Without statistics on disability (i.e., the economic effects of various impairments), the preparers of the first Rating Schedule had to rely on expert judgment informed by the practices of existing programs to assign rating percentages representing the impairment of earning capacity of the average person in civil occupations.

The 1921 schedule was under development for several years, including several provisional versions, before it was formally adopted in 1921. According to the introduction of the first part of the 1921 schedule, which covered neuropsychiatric conditions, the schedule took into account "opinions of leading neuropsychiatrists of the United States; the rating schedules of France, Canada, England, and Belgium; and the accumulated experience of this Bureau." Similarly, other parts of the schedule—for example, surgical disabilities; amputations, fractures, and their sequelae; and general medicine—were based on the opinions of leading surgeons, orthopedic surgeons, and internists, respectively, as well as on the rating schedules of other countries.

The 1921 schedule dealt with the problem of lack of knowledge about the impact of impairment and functional limitation on disability in several ways. These included using degree of impairment as the measure of impairment of earning capacity although this approach ignored vocational factors, and gave discretion to raters to determine the rating percentage rather than specifying criteria for different rating percentages. In most parts of the schedule, the ratings were pegged to a loss, or loss of use of, a body part or system, rather than to the extent to which the person is unable to function in a work setting. The exceptions were psychoses and psychoneuroses in the neuropsychiatric section. Disability from psychoses and psychoneuroses was to be determined by degree of "social inadaptability," defined as "the degree to which the claimant is able to adjust himself to his social and industrial environment."¹⁴ These conditions could be

¹³ President's Commission, *Veterans' Administration Disability Rating Schedule*, 34. According to the Bradley Commission staff report on the development of the Rating Schedule, the advisory board was formed and "compiled, with the assistance of surgeons in New York, a tentative schedule of ratings."

¹⁴ Veterans' Bureau, *United States Veterans' Bureau*, 14, 15. The 1921 schedule also directed raters to determine average disability not by inability to resume a former occupation but by "the degree to which the claimant is incapacitated from carrying on any substantially gainful occupation."

rated at 25 percent (partial social inadaptability but not requiring supervision), 50 percent (partial social inadaptability but requiring supervision), and 100 percent (complete social inadaptability).

For some disabilities, the extent of disability was left to the rater to determine, with either no criteria or general criteria stated in the schedule. In these cases, the schedule gave the rating as a range of percentages. For example, rheumatoid arthritis could be rated from temporary partial 25 percent to permanent 100 percent “dependent upon the number of joints involved, degree of involvement, and loss of function.” In other cases, a range was given without evaluation criteria. For example, impairment of the sciatic nerve affecting the upper half of the thigh could be rated from 40 to 60 percent, if it affected the lower third of the thigh, the ratings could be from 30 to 50 percent, but no guidance on determining which percentage should be assigned was given. Most of the ratings were very specific, however, in assigning a specific rating percentage to the impairment or degree of impairment.

The VA Rating Schedule was most like the one used by the California workers' compensation program. It was comprehensive rather than limited in the number of injuries and diseases included, and it compensated for permanent partial disability for as long as the disability lasted rather than for a fixed time or amount. The California schedule was very different in one respect, however. It adjusted the impairment rating for occupation and age to account better for impairment of earning capacity than a strictly impairment-based rating.

When Congress revised the statute in 1924 to base compensation on the impairment of earning capacity that the service-connected injuries would cause in civil occupations by adding the phrase, “similar to the occupation of the injured man at the time of enlistment,” the Veterans Administration developed a new schedule with added tables to adjust the impairment ratings by occupation. This approach proved to be very difficult to administer, in part because many veterans did not have an occupation when they enlisted, and basing compensation on part-time jobs during high school was not satisfactory.

Under the Economy Act of 1933, the Roosevelt administration tried to cut veterans' benefits, for example, by reducing the compensation levels. The administration planned to reduce the rolls another way, by switching from 10 to 4 rating levels—25, 50, 75, and 100 percent. The main effect would have been to eliminate compensation for veterans rated 10 or 20 percent and reduce it for those rated 30 and 40 percent (to 25 percent), 60 and 70 percent (to 50 percent), and 80 and 90 percent (to 75 percent). This schedule was withdrawn before it took effect, and a new 1933 schedule was developed with the 10 rating levels from 10 to 100 percent, but without the occupational adjustments in the 1925

schedule. The basis for compensation reverted to the one in the original 1917 act: “The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations.” Congress set the schedule of benefits on the basis of the average entry-level earnings of an unskilled adult male working as a common laborer (Pub. L. No. 76-257)

Although the 1945 Rating Schedule was a comprehensive revision of the 1933 schedule, in the absence of empirical data on the average earnings of service-disabled veterans at the different rating levels, it was still based on professional judgment or, as the head of the VA rating schedule board put it in 1952, “the consensus of informed opinion of experienced rating personnel, for the most part physicians.”¹⁵ These were members of a Disability Policy Board. They estimated “the relative effects of different levels of severity of a condition...on the average veteran’s ability to compete for employment in the job market,” based on a detailed description of the etiology and manifestations of each of the conditions in the schedule.¹⁶ As a result, adjustments were made in some rating percentages, but many were continued from the 1933 schedule. Amputation of the arm at the shoulder, for example, has been rated 90 percent since 1933 (in the 1921 schedule, it was 94 for the dominant arm, 85 for the non-dominant arm). Complete paralysis of the middle radicular nerve group has been rated 70 percent (dominant) or 60 percent (non-dominant) since 1921.

In summary, most of the rating percentages in the VA Rating Schedule are based on degree of impairment, meaning the extent of anatomical loss or functional limitation of a body part or system. With the exception of ratings for mental disorders and the epilepsies, they are not based on direct measures of the capacity of a person to function in everyday life or in the workplace. Instead of looking at the net impact of impairments on an individual’s capacity to function, it uses a formula to combine the ratings of multiple impairments that is less than additive, based on the “whole person” concept, although some injury or illness combinations may be multiplicative in their impact on overall function.

I.5 Relationship of Rating Levels to Average Earnings

Impairment of earning capacity is not the same as loss of actual or expected earnings. As explained earlier, the concept was developed in recognition that pre-injury wages are not necessarily a fair measure of impairment of earning capacity in every case. The VA Disability Compensation Program modified the concept somewhat by introducing the notion of “average” impairments of earning capacity, sometimes expressed as the impact that given impairments would have

¹⁵ President’s Commission. 1956a:33.

¹⁶ General Accounting Office (GAO), *VA Disability Compensation*.

on an average person. This was done intentionally “to give the injured man every inducement to rehabilitate himself. His compensation, since it is based on the ‘average impairments of earning capacity,’ is not decreased if he succeeds in raising himself to his former earning capacity.”¹⁷

The VA Disability Compensation Program adopted an impairment-based rating schedule, which was the most common basis for compensation in use in 1917 by state workers' compensation programs and private accident and disability insurance companies. The original drafters of the 1917 act were aware of the limited state of knowledge about the impact of injuries and diseases on earnings and included the following directive after the sentence about basing compensation on the average impairments of earning capacity:

The bureau shall from time to time readjust this schedule of ratings in accordance with actual experience (Pub. L. No. 90, Art. III, § 302[2] [1917]).

As shown in section I.3.B of this report, the Rating Schedule has gone through several comprehensive iterations, most recently in 1945. Most, but not all, of the body systems have been revised comprehensively one or more times since 1945, usually to update medical terms and criteria for determining severity rather than change the rating percentages assigned to each level of severity. The most recent round of reviews, for example, which resulted in the revision of 11 of the 14 body systems, focused explicitly on medical updating rather than on increasing or decreasing ratings in response to advances in medical care and assistive technology or to changes in the workplace (Schedule for Rating Disabilities; The Genitourinary System, 54 Fed. Reg. 34531, August 21, 1989).¹⁸

Although average impairment of earning capacity is not the same as the average loss of actual earnings, the latter can be a useful check on how effective the Rating Schedule is generally in predicting average impairment of earning capacity, that is, as the ratings go up, earnings tend to go down. Determining the average loss of actual earnings is also useful in assessing how well the amount of compensation for each rating level equalizes the earnings of veterans with and without disabilities, that is, the adequacy of compensation. This was the reason that the Commission asked CNAC to compare the average earned income losses of veterans with service-connected disabilities with VA compensation amounts to see if the compensation replaces the losses, on average. Before

¹⁷ Douglas, “War Risk Insurance Act,” 461–483, at 474.

¹⁸ The 1989 Advanced Notice of Proposed Rulemaking (ANPRM) announcing VA’s intention to revise each of the 14 body systems comprehensively, beginning with the genitourinary system, noted that VA’s “primary concern in this ANPRM is the medical criteria used to evaluate genitourinary disabilities and not the percentage evaluations presently assigned to each level of severity.” (The same language was included in the ANPRMs issued for each body system in the 1989-1991 period, which resulted in the review and revision of 11 of the 14 systems.)

turning to the results of the CNAC study, however, it is informative to review the two earlier efforts to determine average actual earnings losses of veterans with service-connected disabilities and the adequacy of compensation, one by the President's Commission on Veterans' Pensions (known as the Bradley Commission) in 1956 and one by VA (known as the Economic Validation of the Rating Schedule) in 1971. Some of the findings of the CNAC analysis are consistent with these earlier analyses.

I.5.A Bradley Commission—1956

The Bradley Commission surveyed veterans with and without service-connected disabilities asking respondents to self-report their earnings and total income. The median total income of veterans with disabilities, including compensation, was about three percent less than the median income of all veterans.¹⁹ The Bradley Commission concluded that incomes were about equal, because veterans with disabilities did not have to pay income tax on their compensation.

When median incomes by rating level were compared with those of all veterans, however, some differences emerged. While those rated 10 through 80 percent had average incomes a few percent higher or lower than all veterans, those rated 90 percent had incomes 25 percent higher and those rated 100 percent, or totally disabled, had incomes 30 percent lower on average than all veterans. The Bradley Commission was concerned that, since no study of actual impairment of earning capacity had been made previously and since the standard was predominantly based on physical disabilities affecting manual laborers, compensation might not be adequate and equitable. On the basis of the data it collected the Commission concluded that:

While there are some important exceptions, it appears that—despite the inadequacies discussed above—on the whole veterans' compensation tends to work out in such a way that the average wage loss of those who are disabled is made up through compensation.²⁰

The Bradley Commission recommended, however, that the practice of equal increments between compensation amounts be changed to one in which the increase in amount of compensation be greater as the rating percentage increased, because of the finding that the incomes (including compensation) of those rated 100 percent were substantially less than those of nondisabled veterans.²¹ In response, in 1957 Congress began to increase the compensation

¹⁹ President's Commission, *Finding and Recommendations*, 160. The difference was calculated from the data in Chart II.

²⁰ President's Commission, *Finding and Recommendations*, 165–166.

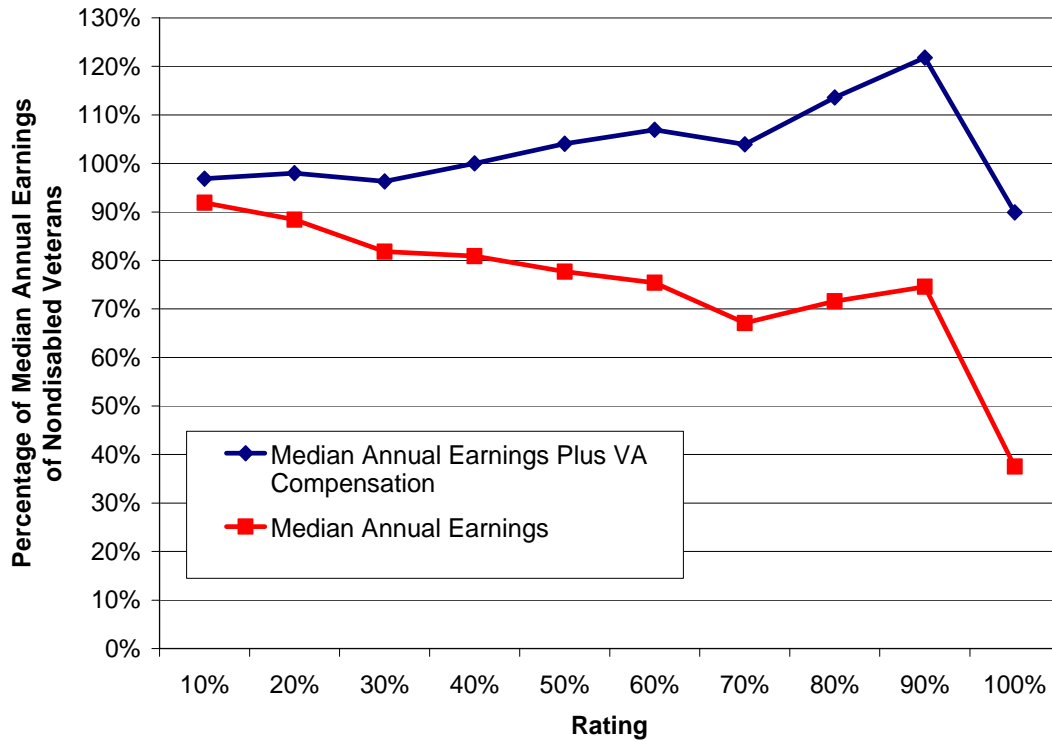
²¹ *Ibid.*, 174–175.

for veterans rated 100 percent relative to the other rating levels. Since 1957, the percentage jump in compensation from the 90 to 100 percent rating levels has increased steadily, and the increments have also increased at lower levels so that the straight line relationship between the rating and compensation has become more of a curve.²²

When the Bradley Commission looked at earnings rather than total income by level of disability, it found that while compensation generally made up for loss in earnings, those rated 100 percent still had about 10 percent less than the earnings of nondisabled veterans (Figure 7.1). The commission did not make comparisons by body system, but it did compare total median income (including compensation) of veterans having general medical or surgical disorders with veterans having psychiatric or neurological disorders, relative to nondisabled veterans. The comparison found that veterans with psychiatric or neurological disorders had median total incomes lower than veterans with general medical or surgical disorders at 9 of the 10 rating levels, and substantially less at the 30, 50, 70, and 100 percent levels (Figure 7.2).

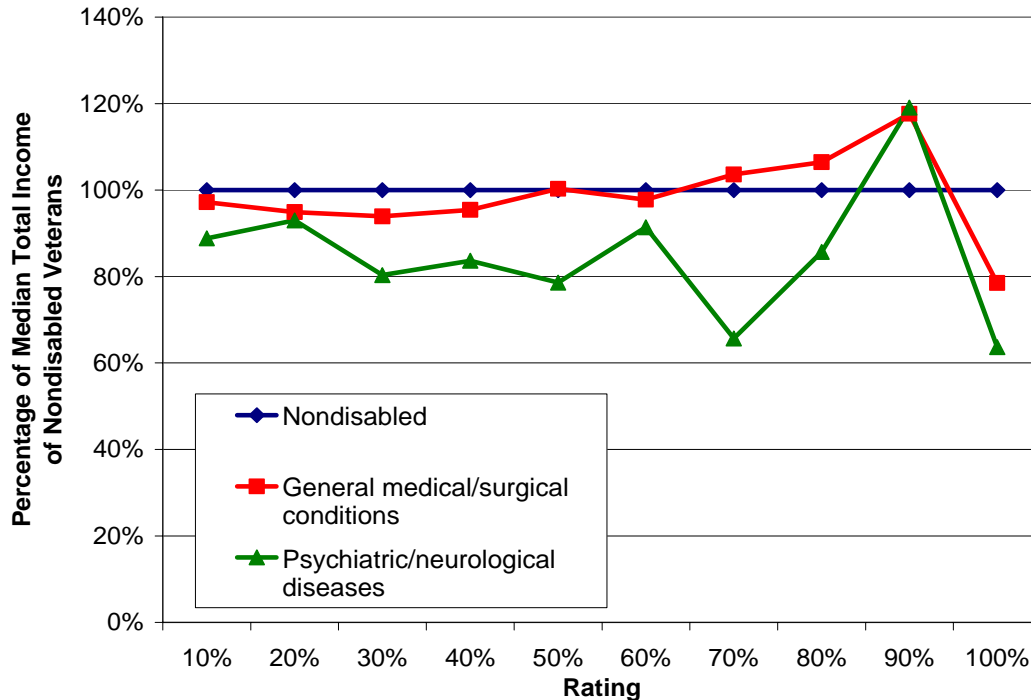
²² Economics Systems, *VA Disability Compensation Program*, 18.

Figure 7.1 Median annual earnings compared with earnings plus annual compensation of disabled veterans, as percentage of median annual earnings of non-disabled veterans, by combined rating level: 1954–1955.



SOURCE: President’s Commission on Veterans’ Pensions. 1956. *Survey of disabled veterans: Analysis of statistical data on income, employment, and other characteristics*. Staff Report Number VIII, Part C, of the Bradley Commission Report. House Committee Print No. 286, Committee on Veterans’ Affairs, 84th Congress, 2nd Session, August 10, 1956, Table 33.

Figure 7.2 Median annual total income of disabled veterans as percentage of median annual total income of non-disabled veterans, by combined rating degree: 1954-1955



SOURCE: President's Commission on Veterans' Pensions. 1956. *Survey of disabled veterans: Analysis of statistical data on income, employment, and other characteristics*. Staff Report Number VIII, Part C, of the Bradley Commission Report. House Committee Print No. 286, Committee on Veterans' Affairs, 84th Congress, 2nd Session, August 10, 1956, Table 22.

I.5.B Economic Validation of the Rating Schedule (ECVARS)—1971

In 1971, VA conducted a detailed evaluation of the average (median) earnings associated with one or more rating levels for about 530 of the 700 diagnostic codes (in some cases, closely related codes in terms of disease process or injury type and rating criteria were grouped). The number of rating levels analyzed per diagnostic code varied from 1 to 10, for a total of 1,004 possible comparisons with the average earnings of nondisabled veterans. This effort was called the Economic Validation of the Rating Schedule (ECVARS).

To recap the results of ECVARS, the average percentage loss of earnings of service-connected veterans was less than their rating percentage in 82 percent of the comparisons (820 of 1,004), more than the rating percentage in 11 percent of the comparisons (110 of 1,004), and about the same in 7 percent of the

comparisons (74 of 1,004).²³ Nearly three-quarters of the cases (81 of 110) in which the average earning loss percentage was greater than the rating percentage were in the digestive, neurological and convulsive, and mental disorders systems, three body systems that had not been comprehensively updated since 1945.²⁴

When the value of compensation was added, the total on average (earnings plus compensation) for service-connected veterans was at least 95 percent of the average earnings of nondisabled veterans in 57 percent of the comparisons (577 of 1,004). Service-connected veterans made between 75 and 95 percent of what comparable nondisabled veterans earned on average in 29 percent of the comparisons, but they made less than 75 percent of what nondisabled veterans earned in 14 percent of the comparisons. Most (84 of 139) of the comparisons in which service-connected veterans made less than 75 percent of nondisabled veterans were in the neurological and mental disorders body systems.

I.6 CNA Corporation (CNAC) Study—2007

CNAC was asked to analyze 2004 data on veterans with service-connected disabilities in different body systems and at different rating levels and compare their earned income (earnings plus benefits) with the earned income of a demographically similar group of nonservice-disabled veterans (“comparison-group veterans”). The purpose of the analysis was to help answer the question posed by this Commission, “How well do benefits provided to [service-disabled] veterans meet the congressional intent of replacing average impairment in earning capacity?” The statistics on earnings by rating percentage and by body system are also useful for evaluating the effectiveness of the Rating Schedule in predicting actual earnings, which was recommended by the IOM Committee on Medical Evaluation of Veterans for Disability Compensation.²⁵

The earnings data were obtained by matching veteran records with Social Security earning records. The assumptions are that, for comparison purposes, the average earnings of comparison-group veterans are about the same as what service-connected veterans would be making on average if they had not been

²³ “About the same” means earnings between 90 and 110 percent of the rating percentages of nondisabled veterans.

²⁴ The mental disorders section of the Rating Schedule was comprehensively revised in 1996.

²⁵ IOM, *21st Century System*, 101.

disabled in service and are a reasonable although not exact measure of average impairments of earning capacity.²⁶

CNAC, in consultation with the Commission, stratified the service-connected veterans into four rating percentage groups: 10 percent, 20 through 40 percent, 50 through 90 percent, and 100 percent. Also in consultation with the Commission, CNAC grouped the service-connected veterans by the body system of their primary (i.e., highest-rated) disability and also looked at PTSD separately from the rest of the mental disorders. Veterans receiving special monthly compensation were looked at separately, as were veterans who have Individual Unemployability (IU) status. CNAC stratified service-connected veterans by age group: 18–29, 30–39, 40–49, 50–60, 61–64, 65–69, 70–74, and 75 and older. Finally, CNAC developed a comparison group of veterans not receiving disability compensation from VA or DoD who are demographically equivalent in age, race, gender, and education at time of entry into military service. The detailed results of the CNAC analysis of veterans' earnings are in Chapter 2 of their report to the Commission.²⁷

I.6.A Average Earned Income—Overall

At the most aggregate level, as might be expected, service-connected veterans on average earned less than the comparison group (Figure 7.3).²⁸ For example, in the 30–39 and 40–49 age groups, service-connected veterans averaged about \$43,000 a year, compared with the \$48,000 averaged by comparison-group veterans. Moreover, the average earnings of service-connected veterans began to drop after age 49 while those of comparison-group veterans stayed about level until after age 60. Part of the reason for this is that service-connected veterans at all ages are less likely to be employed, especially those in their 50s and 60s, than their non-service-connected peers.²⁹

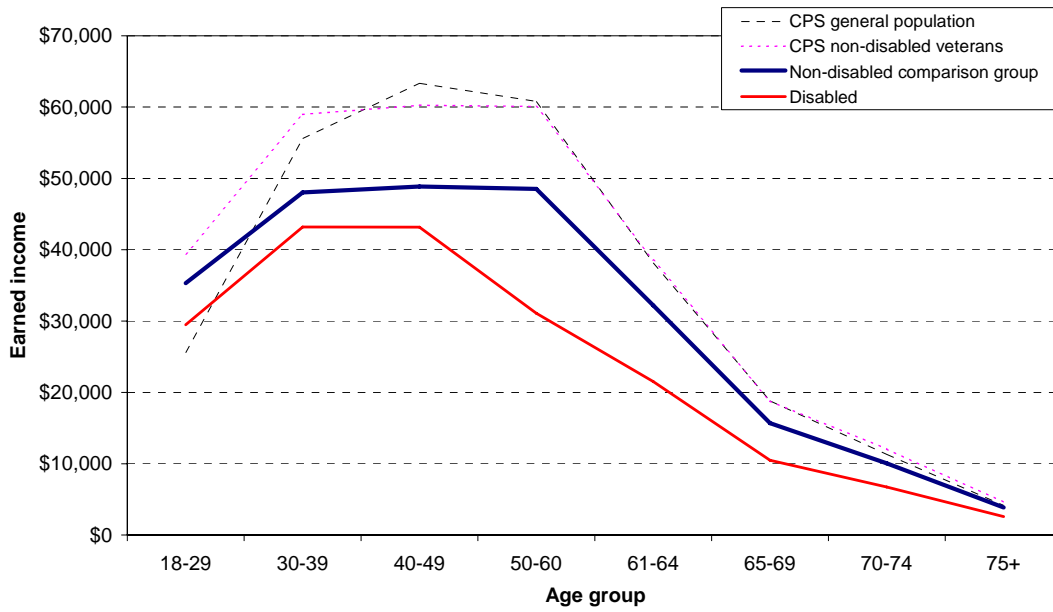
²⁶ Not exact to the extent that some service-connected veterans are not working to their maximum ability. Also, it should be noted that some of the members of the comparison group are likely to have disabilities that are not service connected.

²⁷ CNAC, *Final Report for the Veterans' Disability Benefits Commission*, Ch. 2.

²⁸ CNAC, *Final Report*, Figure 5. Unless otherwise indicated, the data cited in this report are for men, because there are too few service-connected women for statistical robustness. CNAC's final report has tables for women in an appendix (Appendix A).

²⁹ The wage gap is \$17,000 a year for veterans in their 50s, after which the gap steadily closes to about \$1,000 a year for those age 75 and older. The employment rate gap is about 5 percentage points for veterans in their 20s and 30s, increases to 24 percentage points in the 50s, and decreases after age 60 (Figure 4 in CNAC report).

Figure 7.3 Average Earned Income of Service-Connected and Nonservice-Connected Veterans (men): 2004

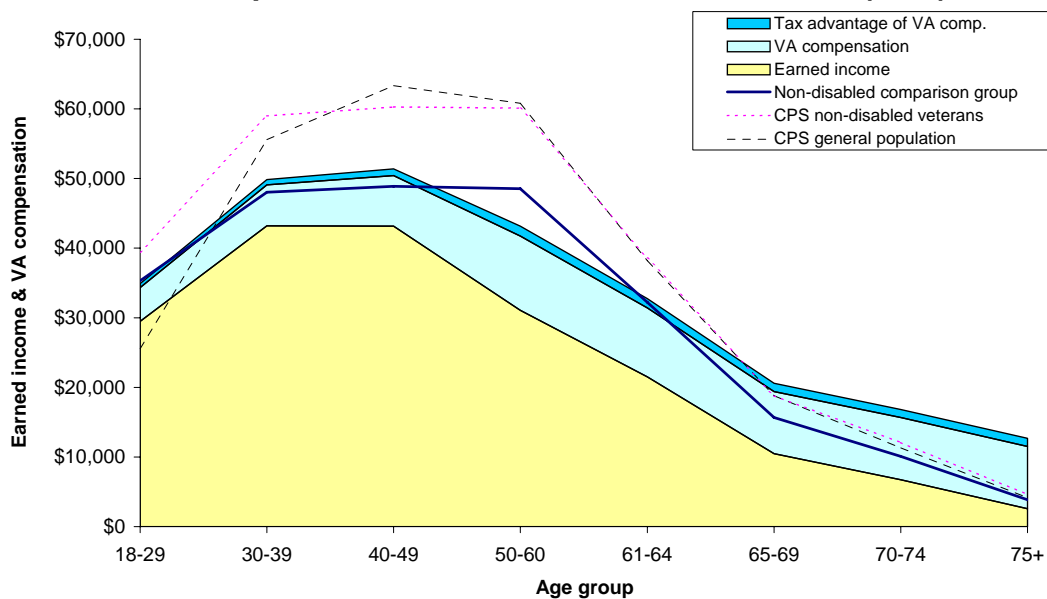


SOURCE: CNAC, *Final Report*, Page 33.

I.6.B Average Earned Income Plus Compensation—Overall

When CNAC compared the average earned income plus compensation of service-connected veterans with the earned income of comparison-group veterans, it found that service-connected veterans received more dollars than the comparison group in some age brackets (e.g., 30–49, 61 and older) and less in other age brackets (18–29, 50–60) (Figure 7.4).³⁰ “Hence, on average,” the authors of the CNAC report concluded, “VA compensation does a pretty good job of replacing lost earning capacity.”³¹

Figure 7.4 Average Earned Income and the Taxable Equivalent of VA Compensation of Service-Disabled Veterans (men)



SOURCE: CNAC, *Final Report*, Page 34.

I.6.C Average Earned Income—By Rating Group

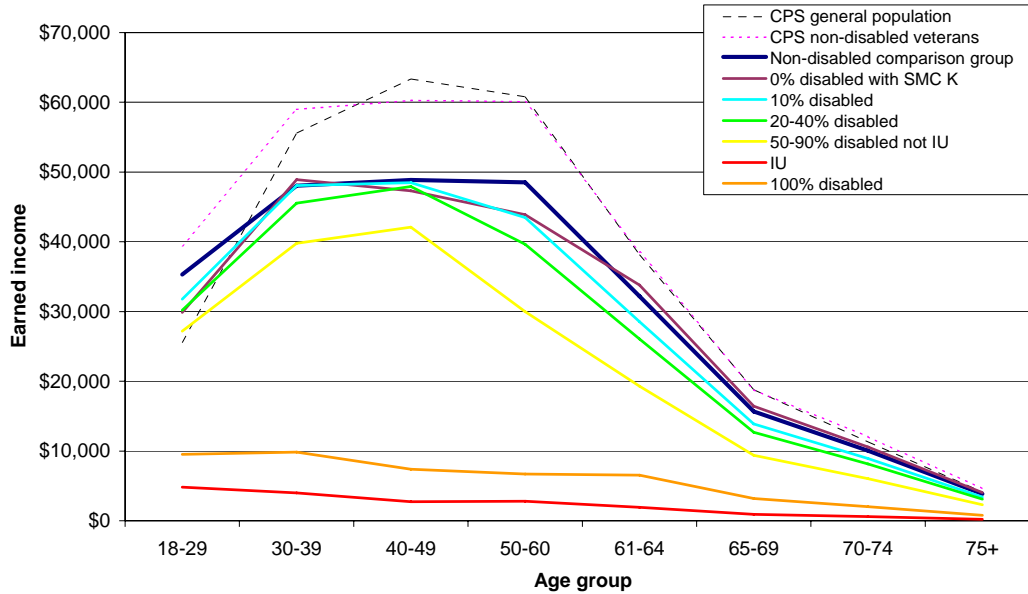
CNAC found that average earned income differed by rating group, with those rated 10 percent earning less than comparison-group veterans, those rated 20–40 percent earning less than those rated 10 percent, and so on, with those rated 100 percent earning less on average than those at lower rating levels (Figure 7.5).³² The differences are evident for every age group, and they are greatest for the 50–60 year old age group (Table 7.1).

³⁰ In this and similar comparisons involving compensation, the compensation has been adjusted (i.e., increased) to account for the fact it is not taxed).

³¹ CNAC, *Final Report*, 34.

³² Veterans rated 50–90 percent who have Individual Unemployability (IU) status have even less earned income on average than veterans rated 100 percent according to the schedule, but this finding is affected by the requirement that IU veterans not have substantial earnings.

Figure 7.5 Average Earned Income of Service-Connected Veterans by Rating Group and Nonservice-Connected Comparison Group (men): 2004



SOURCE: CNAC, *Final Report*, Page 36.

Table 7.1 Average Earned Income of Service-Connected Veterans Ages 50–60 by Rating Degree, as a Percentage of Earned Income of Comparison-Group Veterans: 2004

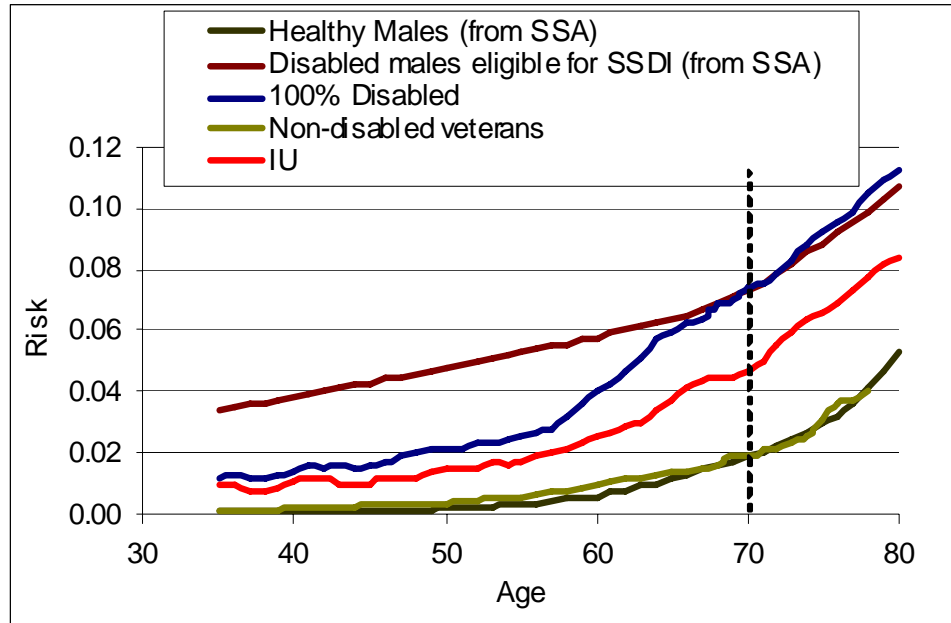
DISABILITY STATUS	AVERAGE EARNED INCOME	
	Dollars	Percent of comparison-group average earned income
Non-service connected	\$48,500	100%
10%	\$44,000	91%
20-40%	\$40,000	82%
50-90%	\$30,000	62%
100%	\$6,500	13%

SOURCE: CNAC, adapted from *Final Report*, Page 36.

CNAC determined mortality rates by rating level as well as earnings. Although mortality rates are different than rates of earning, finding that the average mortality rate increases with rating percentage gives additional support to a finding that the Rating Schedule is effective at identifying how healthy veterans

are, which is related to earning capacity. CNAC found that mortality rates do increase monotonically with each increase in the rating percentage, even at the lowest rating levels (Figure 7.6).

Figure 7.6 Comparison of Mortality Rates of Healthy Males and Male Service-Connected Veterans, by Rating Percentage Group



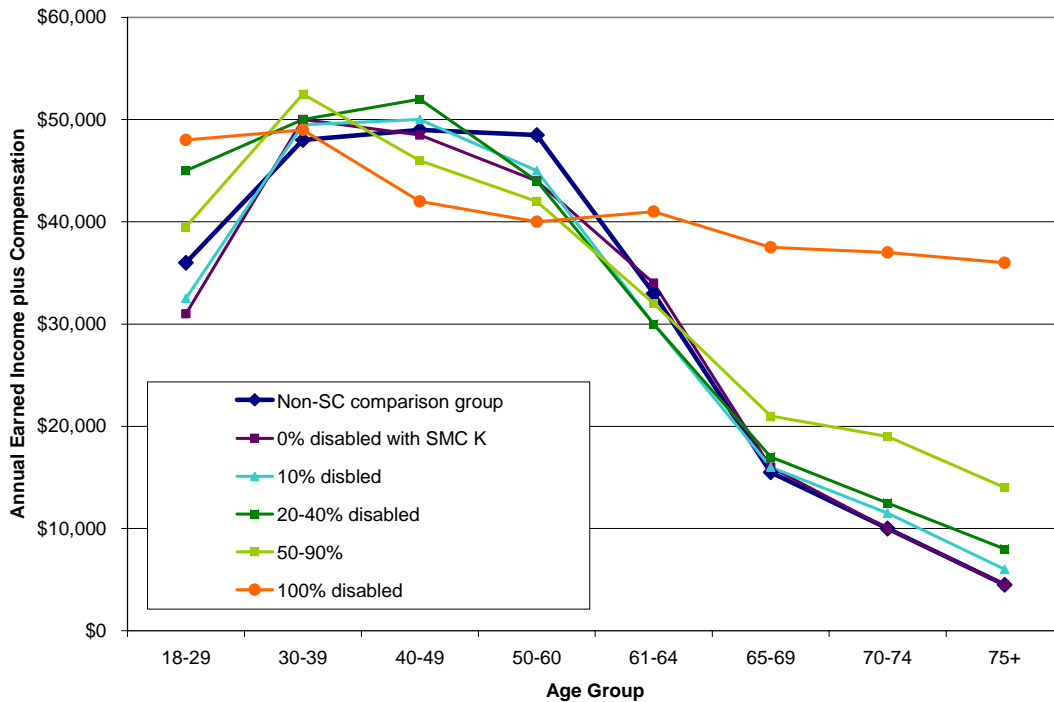
SOURCE: CNAC, *Final Report*, Page 171.

I.6.D Average Earned Income Plus Compensation—By Rating Level

Generally, service-connected veterans rated 10 percent or 20–40 percent receive compensation that, when added to average earnings, is between 90 percent and 110 percent of the average earnings of comparison-group veterans when they are ages 18–69. Beginning with the 70–74 year old group, the total of earnings and compensation begins to be significantly more than the earnings of the comparison-group veterans (Figure 7.7). This result is consistent with the intent of the compensation program established in 1917: that benefits would be paid for life, rather than just during the time the individual is expected to work.

Veterans rated 50–90 percent or 100 percent tend to have more dollars from earnings and compensation when younger (39 and under), less from age 40–60 (because their earnings, already low, fall off rapidly), and significantly more after age 60 (when the earnings of the comparison-group veterans fall off rapidly to very low levels as they leave the work force) (Figure 7.7).

Figure 7.7 Average Annual Earnings Plus Compensation of Veterans by Rating Percentage Group and Earnings of Comparison-Group Veterans (men): 2004

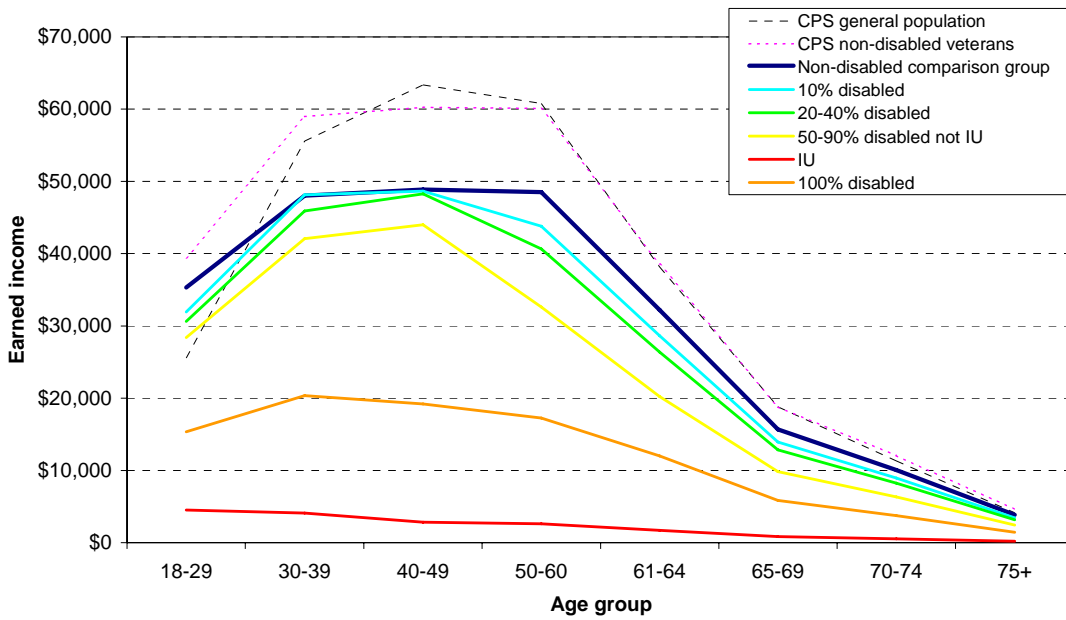


SOURCE: CNAC, adapted from *Final Report*, Pages 37-42.

I.6.E Average Earned Income—By Body System of Primary Disability

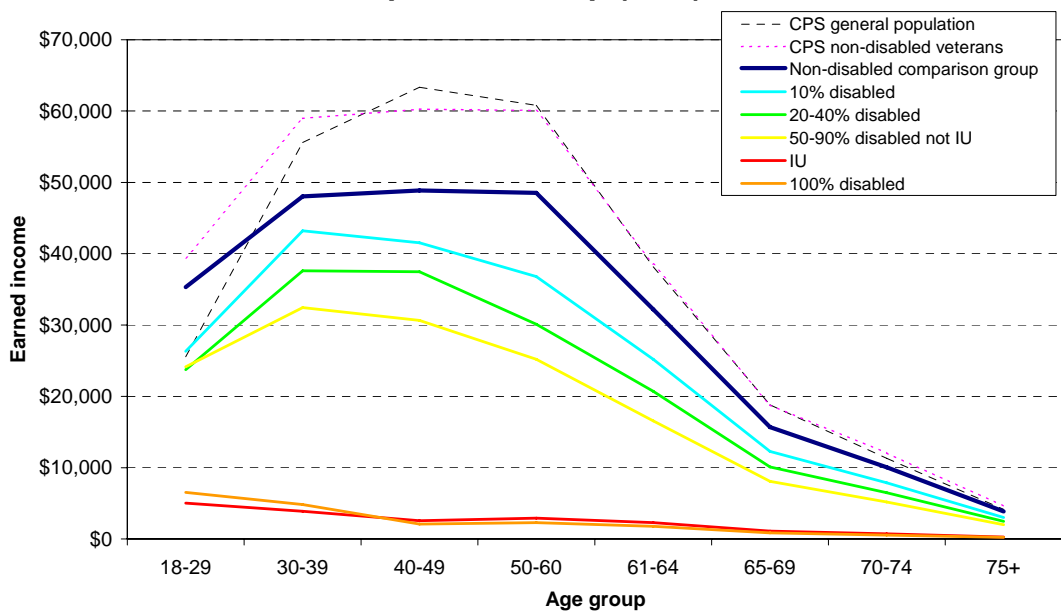
CNAC analyzed average earned income and employment rates by body system and rating percentage to see if there were significant differences. CNAC’s final report contains figures for each body system, separately for men and women. The analysis found that the patterns for the physical disabilities (e.g., musculoskeletal, hearing, vision, digestive, skin, endocrine, and other nonmental body systems) were very similar. The patterns for PTSD and mental disorders other than PTSD were also very similar, but very different from those for the physical disabilities. It is possible, therefore, to capture the essence of this analysis with two figures, one of average annual earnings of veterans with *physical* disabilities as their primary diagnosis and the other of average annual earnings of veterans with *mental* disabilities as their primary diagnosis (Figures 7-8 and 7-9).

Figure 7.8 Average Annual Earning of Service-Connected Veterans with a Physical Primary Disability, by Rating Group, and Nonservice-Connected Comparison Group (men): 2004



SOURCE: CNAC, *Final Report*, Page 49.

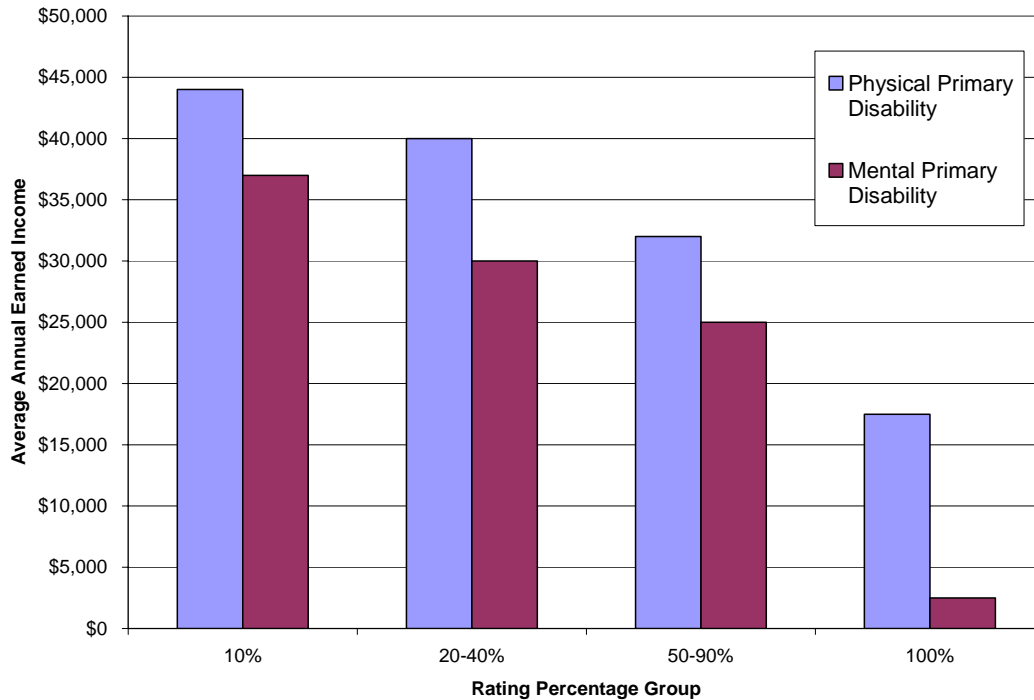
Figure 7.9 Average Annual Earnings of Service-Connected Veterans with a Mental Primary Disability, by Rating Group and Nonservice-Connected Comparison Group (men): 2004



SOURCE: CNAC, *Final Report*, Page 49.

For every age group and rating percentage group, the average earned income of service-connected veterans with mental primary disabilities is less—substantially less at higher rating percentages—than the average earned income of service-connected veterans with physical primary disabilities. For example, in the peak earning years—ages 50–60—veterans rated 10 percent for mental primary disabilities earn 86 percent of what veterans rated 10 percent for physical primary disabilities earn. Those rated 20–40 percent for mental primary disabilities earn 77 percent as much, those rated 50–90 percent earn 69 percent as much, and those rated 100 percent earn only 11 percent as much, on average, as those with the same rating percentage but with primary physical disabilities (Figure 7.10).

Figure 7.10 Comparison of Average Earnings of Service-Connected Veterans Ages 50-60 with Primary Physical Disabilities and with Primary Mental Disabilities (men): 2004



SOURCE: CNAC, adapted from *Final Report*, Page 49.

I.6.F Average Earned Income Plus Compensation—By Body System of Primary Disability

For this part of the analysis, CNAC compared the present value of the average lifetime earned income (earnings plus benefits plus compensation) of service-connected veterans with the present value of the average lifetime earned income

(earnings plus benefits) of comparison-group veterans.³³ This approach makes it possible to take into account significant differences in average age of first entry into the compensation system across rating percentage groups and body systems of primary disability. It also takes into account the higher average mortality rate of service-connected veterans compared with the comparison-group veterans.³⁴

First, CNAC calculated the present average value of the lifetime earned income of service-connected men at age 55, the average age of first entry into the compensation system, and calculated the same value for comparison-group veterans. The results were \$250,769 and \$402,268, respectively. When \$148,053, the average lifetime present value of compensation, was added to the earnings of service-connected veterans, the total of \$398,822 was 99 percent of the expected earnings of the comparison group (\$398,822 divided by \$402,268), or close to parity. This “earnings ratio”—0.99—indicates that the amount of compensation is about the same as the amount of lost earnings for the typical service-connected veteran.

When the same calculation is made for different ages of first entry, the picture changes. Veterans entering at older ages than 55 tend to receive compensation greater than their expected earnings losses (Table 7.2).

Table 7.2 Earnings Ratio at Age of First Entry

AGE AT FIRST ENTRY	MEN	WOMEN
25	1.05	1.05
35	1.02	1.03
45	0.96	1.00
55	0.97	1.00
65	1.51	1.63
75	2.62	3.59

NOTE: Average age at first entry is 55 for men and women.

SOURCE: CNAC, *Final Report*, Page 55.

³³ CNAC, *Final Report*, § 2.3, 51–62; Shahnasarian, *Assessment of Earning Capacity*. The present value of lifetime earned income is the same as the dollar value of an annuity which, if invested, would yield an income stream that compensates for the loss of earning capacity. This is also the methodology used in damage suits to determine compensation for loss of earning capacity.

³⁴ CNAC, *Final Report*, 51–53; a more detailed technical description of the methodology for determining present value of lifetime earned income is in Appendix C of the CNAC report.

The picture becomes more complicated if the rating percentage groups are looked at separately by age of first entry (Table 7.3). The earnings ratio shows that compensation achieves between 93 and 111 percent of parity for the average ages of first entry by rating percentage group. It is also near parity for veterans rated 10 percent regardless of age of first entry, and for those rated 20–40 percent or 50–90 percent at ages up to and including average age of first entry but not for those who enter at age 65 or older. In the higher age and rating groups, the present average value of the lifetime earned income begins to exceed the amount of lost earning capacity. At the highest rating percentage—100 percent—veterans entering at younger ages have relatively low average earnings ratios (i.e., they are receiving less in compensation than their expected loss of earnings) but those entering at older ages have relatively high earnings ratios (i.e., they are receiving more in compensation than their average impairment of earning capacity). As the authors of the CNAC report wrote,

Why the difference? For those who become severely service disabled at younger ages, most of their working life is ahead of them. Hence, they incur substantial lost earning capacity for longer periods so it requires more disability compensation to replace lost earning capacity. In contrast, for those who become service disabled at older ages, much of their working years are behind them, so their disability compensation is replacing only the earned income that occurs after they become service disabled.³⁵

Table 7.3 Earnings Ratio by Age of First Entry and Rating Percentages Group (men)

AGE AT FIRST ENTRY	10%	20–40%	50–90%	100%
25	0.99	1.01	1.05	0.87
35	0.99	1.01	1.03	0.80
45	0.96	0.97	0.98	0.83
55	0.93	0.95	1.00	1.04
65	0.97	1.16	1.66	2.50
75	1.03	1.58	3.08	5.60

NOTE: Average age at first entry is bolded. IU recipients are excluded from the 50–90 percent rating group.

SOURCE: CNAC, *Final Report*, Page 56.

³⁵ CNAC, *Final Report*, 56.

CNAC calculated the earnings ratio by rating group and average age at first entry for each body system.³⁶ It found that the results for physical disabilities were very similar and those for mental disorders were also very similar, but they differed markedly between physical and mental disorders (Table 7.4).³⁷ At entry age 25, for example, veterans with a primary physical disability have earnings ratios between 0.95 and 1.10, indicating that they are near parity (i.e., their expected lifetime earnings plus compensation are about the same as the lifetime expected earnings of comparison-group veterans). Veterans with the same age of first entry but with a primary mental disability have lower earnings ratios, between 0.75 and 0.89, indicating lack of parity (i.e., their expected compensation is not making up for lost earnings).

Table 7.4 Earnings Ratio by Age of First Entry and Rating Percentages Group for Veterans with Primary Physical Disabilities (men)

Age at First Entry	Physical Primary Disabilities					Mental Primary Disabilities				
	10%	20-40%	50-90% (not IU)	IU	100%	10%	20-40%	50-90% (not IU)	IU	100%
25	0.99	1.02	1.10	0.75	0.94	0.86	0.83	0.88	0.77	0.75
35	0.99	1.02	1.08	0.71	0.89	0.85	0.82	0.84	0.74	0.69
45	0.96	0.99	1.04	0.76	0.91	0.81	0.78	0.82	0.80	0.73
55	0.93	0.97	1.06	0.99	1.08	0.79	0.77	0.88	1.07	0.95
65	0.98	1.17	1.71	2.56	2.37	0.86	1.04	1.50	2.80	2.40
75	1.04	1.58	3.13	6.08	5.30	0.93	1.57	2.84	6.81	5.61

NOTE: The earnings ratios for average age at first entry are bolded.

SOURCE: CNAC, *Final Report*, Page 59.

As the authors of the CNAC report wrote,

To summarize the earnings ratio findings for male veterans, there is general parity overall. However, when we explored various subgroups, we found that some were above parity, while others were below parity. The most important distinguishing characteristic is whether the primary disability is physical or mental. In general, those with a primary mental disability have lower earnings ratios

³⁶ CNAC, *Final Report*. The tables for veterans with primary musculoskeletal and primary PTSD disabilities are on page 61 of the CNAC report and the rest of the tables are in Appendix D.

³⁷ *Ibid.*, 61. Within the body systems for physical primary disabilities, the earnings ratios are a little smaller for auditory and endocrine, and a little larger for genitourinary and cardiovascular, systems compared with the overall average.

than those with a primary physical disability, and many of the rating subgroups for those with a primary mental disability had earnings ratios below parity. In addition, entry at a young age is associated with below parity earnings ratios, especially for severely disabled subgroups.³⁸

I.6.G IOM Study of the Ability of the Rating Schedule to Compensate for Impairment of Earning Capacity

The report of the IOM Committee on Medical Evaluation of Veterans for Disability Compensation recommended regular analyses of the ability of the Rating Schedule to compensate for average earning losses. The IOM committee also recommended that adjustments be made whenever it is found that step increases in rating percentages do not correlate with decreases in actual average earnings, either by revising the criteria for evaluating severity of disability or changing the amount of compensation paid at each rating percentage level, or both.

IOM Recommendation 4-2: VA should regularly conduct research on the ability of the Rating Schedule to predict actual loss in earnings. The accuracy of the Rating Schedule to predict such losses should be evaluated using the criteria of horizontal and vertical equity.

IOM Recommendation 4-3: VA should conduct research to determine if inclusion of factors in addition to medical impairment, such as age, education, and work experience, improves the ability of the Rating Schedule to predict actual losses in earnings.

IOM Recommendation 4-4: VA should regularly use the results from research on the ability of the Rating Schedule to predict actual losses in earnings to revise the rating system, either by changing the rating criteria in the Rating Schedule or by adjusting the amounts of compensation associated with each rating degree.

The Commission generally agrees with the recommendation of the IOM Committee on Medical Evaluation of Veterans for Disability Compensation that VA periodically analyze the extent to which the Rating Schedule is associated with average earnings losses in the way expected, and make adjustments in the

³⁸ CNAC, *Final Report*, 4-5. CNAC performed the same analysis of women to the extent that more limited data allowed and found very similar results.

criteria for evaluating severity of disability or in the amount of compensation for one or more rating percentages, if necessary. However, the Commission rejected a few of the recommendations since it finds that the VA Rating Schedule is not designed nor intended to predict actual loss of earnings. The Commission wants to ensure that it is clearly understood that the purpose of the periodic analysis is to assess the average impairments of earnings capacity, not to assess the actual earnings of individuals.

I.6.G.a Horizontal and Vertical Equity Assessment

Horizontal and vertical equity are concepts borrowed from the workers' compensation field, where they are used to assess the accuracy of rating schedules and adequacy of benefit levels.³⁹ Equity refers to the provision of equal benefits to workers with the same disability and to providing benefits in proportion to disability for those with different degrees of loss.

Horizontal equity is achieved when the impairment of earning capacity is the same on average for veterans with the same degree of disability. In other words, veterans with the same rating percentage should experience approximately the same impairment of earning capacity regardless of the nature or location of the impairment.

Vertical equity is achieved when impairment of earning capacity increases in proportion to increases in the degree of disability. Veterans with less earning capacity because of service-connected injuries should have higher rating percentages than those with more earning capacity.

The results of the CNAC analysis of earnings of veterans indicate that the VA Rating Schedule does generally provide vertical equity, at least at the body system level (rather than the diagnostic code level) and using rating percentage groups (rather than all 10 rating percentages). For example, the data on average earned income of service-connected veterans provide 293 possible comparisons of earnings between adjacent rating groups across body systems (e.g., between the 10 percent and 20–40 percent groups, between the 20–40 percent and 50–90 percent groups, and between the 50–90 percent and 100 percent groups). The higher rating group had lower average earnings 93 percent of the time, higher average earnings 4 percent of the time, and the same average earnings 3 percent of the time. Of 120 possible comparisons of average earnings of veterans rated 10 percent with those of comparison-group veterans, those rated

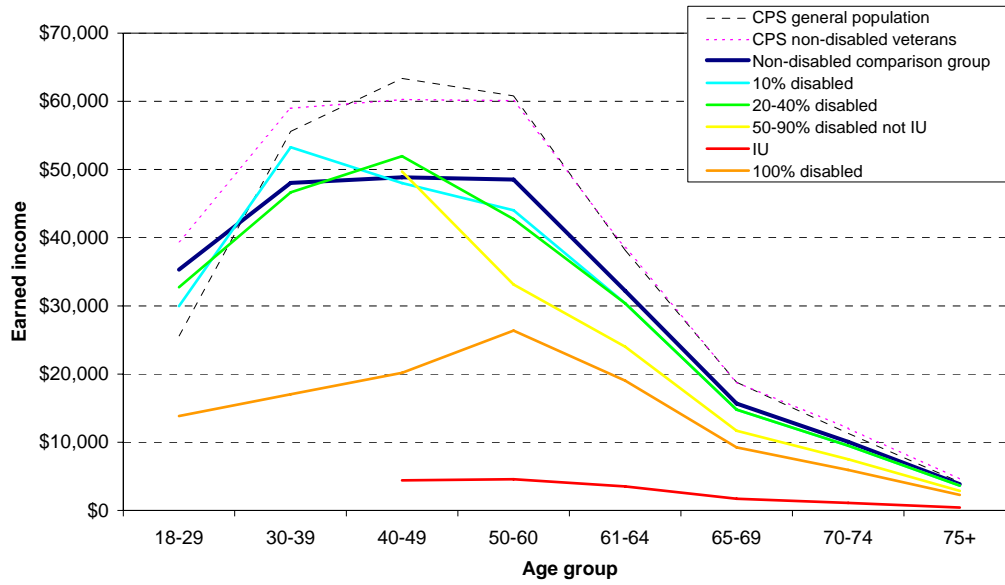
³⁹ See, for example, Berkowitz and Burton, *Permanent Disability Benefits*.

10 percent had lower average earnings than comparison-group veterans 90 percent of the time. In 12 instances, however, veterans rated 10 percent made more than the comparison group, in 8 instances, veterans rated 20 percent made more than the comparison group, and in 1 instance, veterans rated 50–90 percent made more than the comparison group, on average.

In some body systems, the Rating Schedule had some difficulty predicting differences in earnings among those rated 10 percent, 20–40 percent, and those not rated (i.e., comparison-group members) in the under 40 age groupings. In these systems—auditory, digestive, respiratory, endocrine, and genitourinary—the order of ratings was sometimes reversed. For genitourinary disabilities, for example, at age 30–39, the 10 percent rating group had the highest average earned income (\$53,000), the comparison group had the second highest (\$48,000), and the 20–40 percent group had the third highest (\$47,000) (Figure 7.11). For the 40–49 age group, however, those rated 20–40 percent had the highest average earned income (\$52,000), followed by those rated 50–90 percent (\$50,000) and the comparison group (\$49,000). Beginning with the 50–60 age group, however, higher rated veterans do not earn more than lower rated veterans in the genitourinary or any other body systems, although the differences might be narrow or they may earn the same (Figure 7.12).

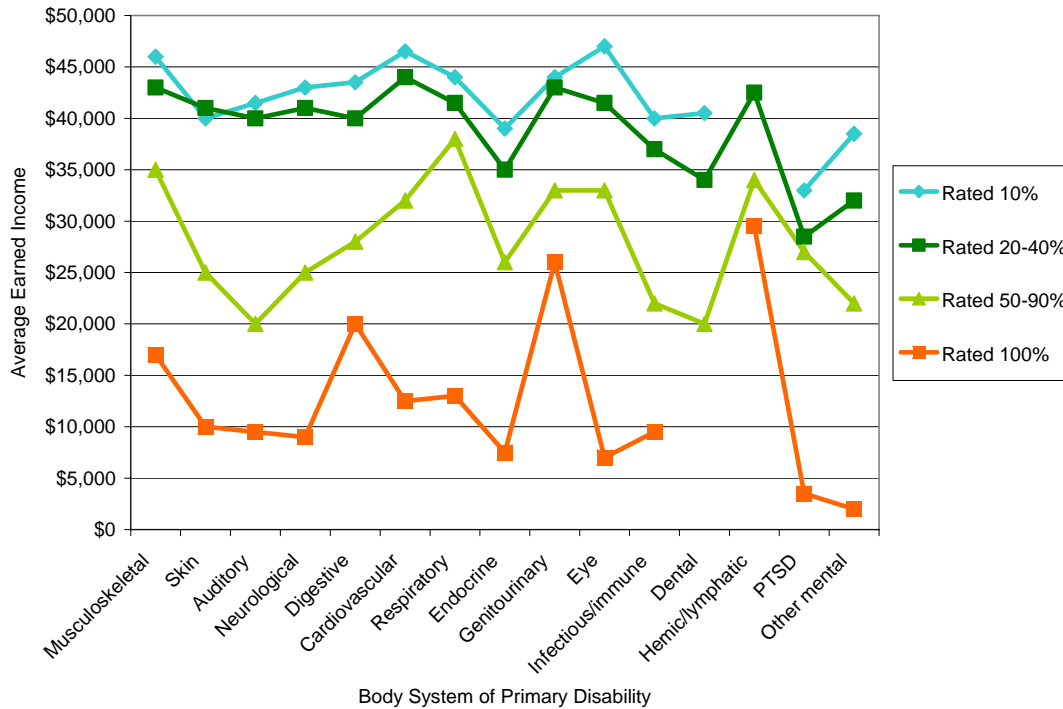
The Rating Schedule clearly lacks horizontal equity between veterans service connected for primary physical and primary mental disabilities (Figure 7.11). This was also a finding of the two previous analyses of the relationship between rating percentages and earnings losses, the Bradley Commission and ECVARS. Looking at each body system separately, horizontal equity among groups with primary physical disabilities is not perfect, although their earnings are relatively similar on average at each rating group percentage level when compared with the earnings of veterans with service-connected primary mental disabilities (Figure 7.12).

Figure 7.11 Average Earned Income of Service-Connected Veterans with Primary Genitourinary Disabilities, by Rating Percentage and Comparison-Group Veterans (men): 2004



SOURCE: CNAC, *Final Report*, Page 222.

Figure 7.12 Earned income of service-connected veterans ages 50-60, by rating percentage, and comparison-group veterans (men): 2004



NOTE: There were not enough cases of dental disabilities rated 100 percent or hemic/lymphatic disabilities rated 10 percent to determine an accurate average earned income for those rating percentage groups.

SOURCE: CNAC, adapted from *Final Report*, pages 47, 211-217.

The CNAC analysis of average earnings of service-connected veterans is a good first pass at evaluating the ability of the VA Rating Schedule to assign rating percentages equitably. Generally, the Rating Schedule meets the vertical equity test, that is, most of the time it successfully predicts the earnings of veterans by assigning higher rating percentages to those who earn less on average. It clearly does not meet the horizontal equity test for veterans with mental disabilities, that is, in each rating percentage group, veterans with primary mental disabilities make substantially less on average than veterans with primary physical disabilities.

The finding that the Rating Schedule has vertical equity is reinforced by CNAC’s analysis of mortality rates, which also vary by the rating percentage in the expected direction, that is, the average mortality rate increases as the rating percentage increases. This means that lower earnings are not due solely to decisions of beneficiaries to work less because they are receiving compensation.

The CNAC analysis does not look at specific diseases or injuries within body systems, except PTSD, and it groups rating percentages. It is possible that a more detailed analysis using the same methodology would reveal equity issues with specific disabling conditions that do not appear in the more aggregate body system-level analysis. Looking at all 10 rating percentages also might reveal conditions or body systems in which those rated at a given percentage earn more than those rated at lower percentages. In various instances, analysis has been hampered by the inability to acquire data. For future analytical purposes, statutory authorization should enable VA and DoD to acquire and analyze data at the individual level.

What is expected from analyzing average earnings of service-connected veterans is that, for each step increase in rating percentage, average earnings decrease monotonically, and that at each rating percentage, average earnings of veterans with that rating percentage should be similar across body systems. If this condition is not met (and assuming that average actual earnings are a reasonable proxy for earning capacity), then some veterans may be over parity or under parity. The Commission believes that adjustments to the compensation levels should not result in reduction of benefits for any recipients.

Based on the findings of the IOM Committee on Veterans' Compensation for Posttraumatic Stress Disorder, the criteria for rating mental disabilities should be specific to the type of disorder as also discussed in Chapter 5 of that report. The IOM committee recommended that "new Schedule for Rating Disabilities rating criteria specific to PTSD and based on the DSM should be developed and implemented."⁴⁰ The recommendation is based on the IOM committee's finding that the general rating formula for mental disorders, which is used for all mental disorders except eating disorders, "lumps together heterogeneous symptoms and signs, allowing very little differentiation across specific conditions."⁴¹ In other words, by trying to address nearly all mental disorders with a single rating formula, the schedule does not address any particular mental disorder very well. VA should decide whether to develop criteria for broad categories that form the basis for sections of the DSM, such as schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, somatoform disorders, and dissociative disorders, or whether to develop criteria for specific disorders, or both. For some specific disorders, such as PTSD, the prevalence among veterans may be so high that VA should develop criteria specific to these disorders.

⁴⁰ IOM, *PTSD Compensation*, 162. The DSM is published by the American Psychiatric Association.

⁴¹ *Ibid.*, 156.

It is possible, based on CNAC data, that adjusting the rating criteria for mental disorders will not equalize earnings losses among those rated 100 percent for mental disabilities and those rated 100 percent for other disabilities. Even if everyone now rated 70 percent for a primary mental disability were rerated at 100 percent, average earnings of these rated 100 percent would not increase enough to be comparable to the earnings of other veterans rated 100 percent.

The Commission does not concur with the recommendation of the IOM Committee on Medical Evaluation of Veterans for Disability Compensation that VA investigate whether including factors in addition to severity of medical impairment, such as the veteran's age, education, and work experience, would improve the ability of the Rating Schedule to predict earnings losses (IOM Recommendation 4-3), because the Commission does not support a policy of considering age or other vocational factors in individual rating determinations.

Recommendation 7.1

Congress should authorize VA to revise the existing payment scale based on age at date of initial claim and based on degree of severity for severely disabled veterans.

Recommendation 7.2

Congress should adjust VA compensation levels for all disabled veterans using the best available data, surveys, and analysis in order to achieve fair and equitable levels of income compared to the nondisabled veteran.

Recommendation 7.3

VA and DoD should be directed to collect and study appropriate data, with due restrictions to ensure privacy. These agencies should be granted statutory authority to obtain appropriate data from the Social Security Administration and the Office of Personnel Management only for the purpose of periodically assessing appropriate benefits delivery program outcomes.

II Compensating for Individual Unemployability

As part of its assessment of the appropriateness of the level of benefits, the Commission evaluated VA's use of Individual Unemployability (IU) as a compensation rating. To accomplish this, the Commission relied on studies

conducted by the Government Accountability Office (GAO) and IOM; it also requested an analysis of IU by CNAC.

II.1 Background

The purpose of IU is to provide VA with a mechanism for compensating veterans at the 100 percent rate who are unable to work because of their service-connected disabilities and for disability ratings that do not meet the Rating Schedule's threshold for receiving the 100 percent rate. To provide a service-connected veteran with IU, VA evaluates the veteran's capacity to engage in substantial gainful occupation as the result of his or her service-connected disabilities. The definition for "substantial gainful occupation" is the inability to earn more than the federal poverty level.

In addition, IU takes into consideration the fact that the disabled veterans often have multiple disabilities. If, for example, a disabled veteran has only one disability; it must be rated 60 percent or more. However, if there are two or more disabilities, at least one disability must be rated at 40 percent or more resulting in a combined 70 percent rating. IU is not provided to veterans who receive a 100 percent rating because it is not necessary. This serves as an advantage for the veteran receiving a 100 percent schedule rating because they are allowed to work.⁴² Individuals who receive an IU rating are unable to engage in gainful employment while collecting the compensation.

The service-connected disabled veteran experiences a significant financial increase with the addition of an IU award. For example, VA compensates a veteran who has a 60 percent rating (without children) \$901 per month compared to \$2,471 per month for someone rated 100 percent disabled.

The adjudication of IU claims by VA raters takes into account the veteran's current physical and mental condition and his or her employment status, including the nature of employment, and the reason employment was terminated.⁴³ Factors that are beyond the scope of inquiry, such as age, non-service-connected disabilities, injuries sustained postservice, availability of work, or voluntary withdrawal from the employment market, are identified and separated to determine the nature of the service-connected disability. Raters are specifically instructed that IU should not be granted if the veteran retired from work for reasons other than for their service-connected disability.⁴⁴

⁴²IOM, *21st Century System*, 191.

⁴³Ibid., 192.

⁴⁴Ibid.

In recent years, IU awards have grown rapidly. The number of service-disabled veterans receiving IU has increased 103 percent from FY 2000 to FY 2005. In comparison, the overall number of veterans receiving any form of disability compensation increased by 16 percent over the same period.⁴⁵ This increase has caused concern regarding the basis for providing IU to service-connected disabled veterans, particularly for those who would likely not be looking for work due to their age and retirement eligibility.

These concerns led to a GAO report in May 2006 that addressed IU.⁴⁶ In its report, GAO found that VA's process for ensuring ongoing eligibility of IU beneficiaries is inefficient and ineffective, and relies on old data, has outdated and time-consuming manual procedures, offers insufficient guidance, and provides weak criteria.

VA has attempted to rectify issues concerning IU. For example, in October 2001, VA published a Notice of Proposed Rulemaking (NPRM).⁴⁷ This document was a draft of a rewritten set of regulations governing IU. However, after much internal and external discord, the NPRM was removed. VA removed the document because the new regulations failed to accomplish the stated purpose. In the same statement, VA announced that it would release a proposal, but has not yet done so. However, VA contends that both younger and older veterans at retirement age are encouraged to participate in vocational rehabilitation, therefore VA makes no judgments about a veteran's right to pursue a vocation.

II.2 CNAC Highlights on IU

The Commission asked CNAC to conduct an analysis of those service-connected disabled veterans who are receiving IU.⁴⁸ The central focus of CNAC's work revolved around determining whether or not the increases in IU were due to veterans' manipulation of the system to get additional compensation. To conduct their analysis, CNAC analyzed the mortality rates of those with and without IU and who concurrently receive Social Security Disability Insurance (SSDI) payments.

⁴⁵ IOM, *21st Century System*, 189.

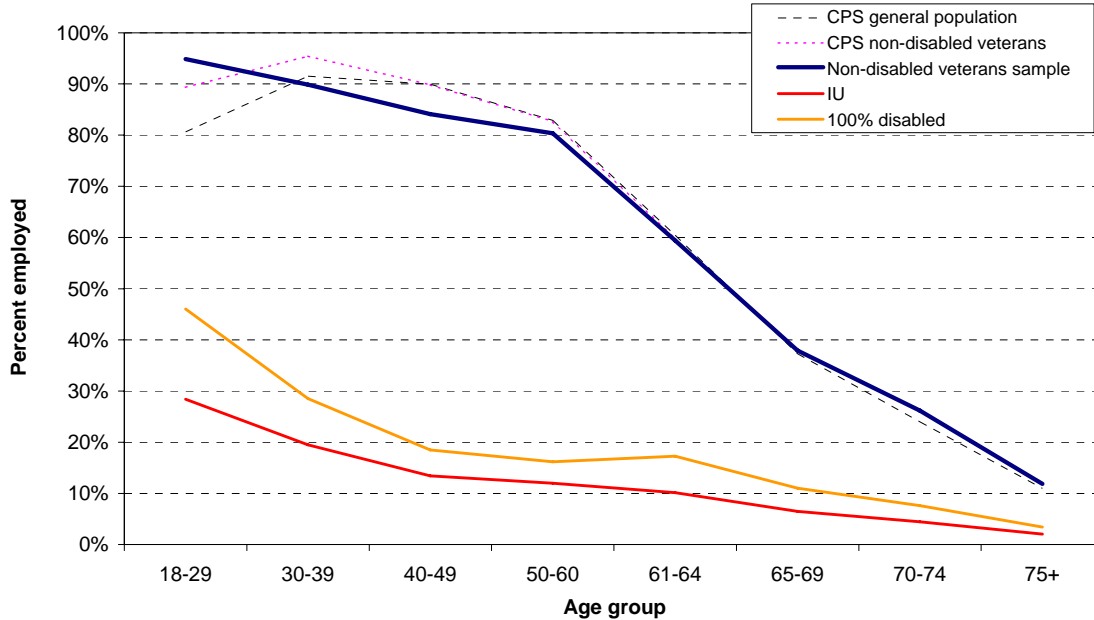
⁴⁶ *Ibid.*, 197.

⁴⁷ *Ibid.*, 193.

⁴⁸ CNAC, *Final Report*, 160.

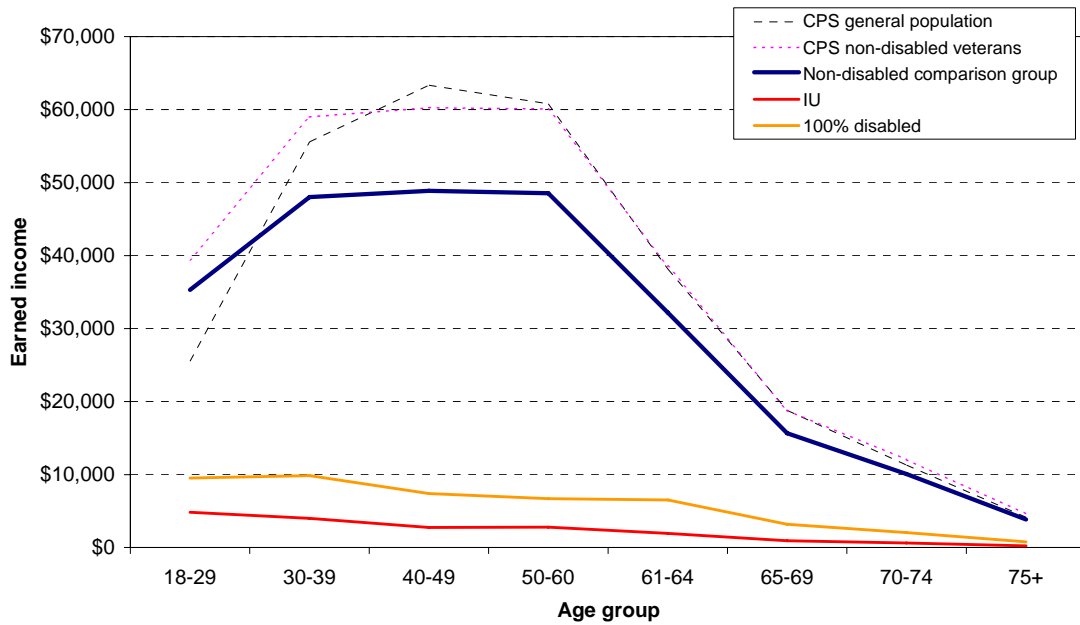
CNAC discovered that certain body systems are more likely to receive IU ratings. For example, 28 percent of those with IU have musculoskeletal disorders and 29 percent have PTSD. CNAC surmised that this may be an area of implicit failure of the Rating Schedule. Second, CNAC discovered that the growth in the IU population is mostly a function of demographic changes. These changes have come about because veterans with service-connected disabilities are facing complications with those disabilities as they age. As a result, CNAC concluded that the increase in IU is not due to veteran manipulation. CNAC also discovered that average employment rates and earned income are consistent between IU and 100-percent disabled veterans with a mental primary diagnosis. In addition, Figures 7-13 and 7-14 show how IU participants earn less and work less than individuals who are rated 100 percent and not IU.

Figure 7.13 Average Employment Rate of IU and 100-Percent Disabled Veterans



SOURCE: CNAC, *Final Report*, Page 167.

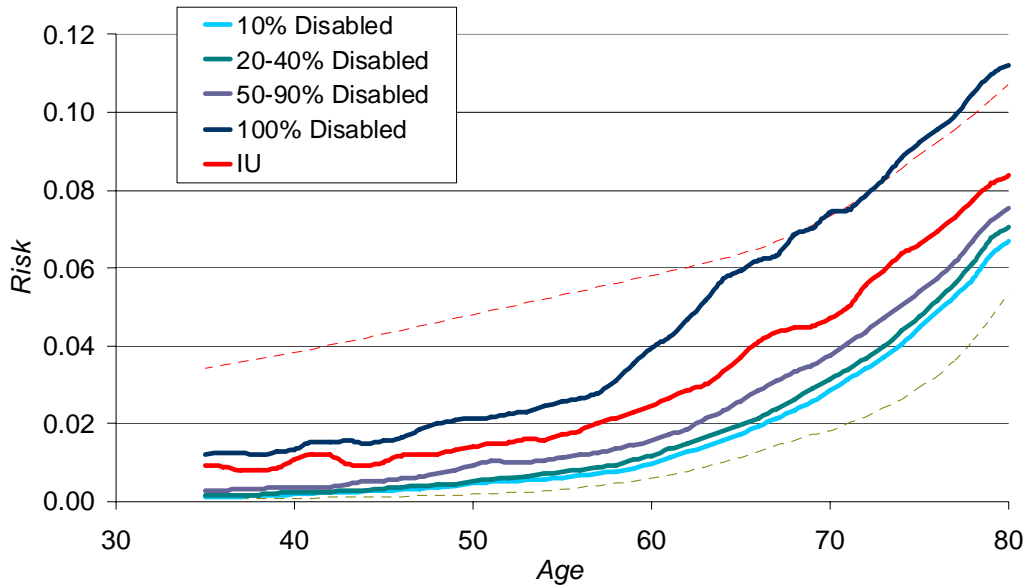
Figure 7.14 Average Earned Income of IU and 100-Percent Disabled Veterans



Source: CNAC, *Final Report*, Page 168.

Mortality rates show that there is an association with disability ratings, including IU. CNAC observed that there is a closely matched pattern as seen in their earnings and quality of life analyses. As shown in Figure 7.15, mortality rates increase with the level of disability rating assigned to a service-connected veteran.

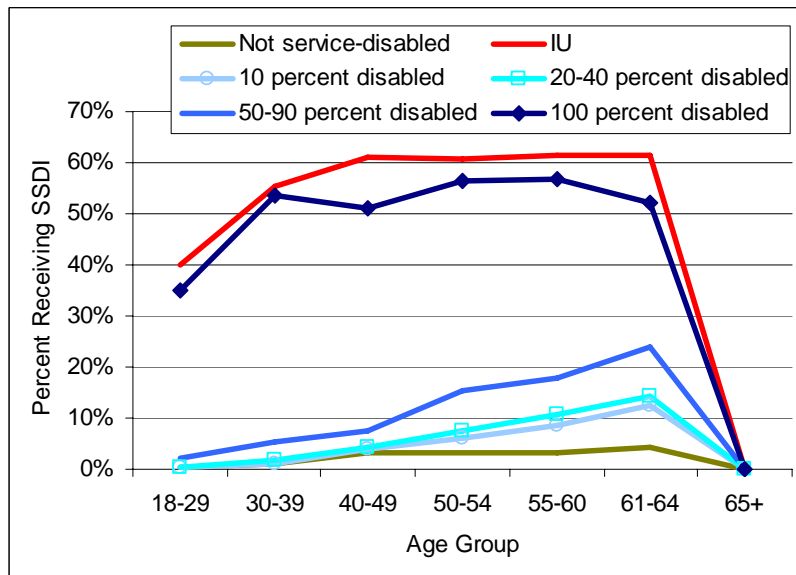
Figure 7.15 Mortality Rates for Service-Disabled Veterans by Rating Group



Source: CNAC, *Final Report*, Page 172.

Finally, CNAC found that SSDI is similar in its eligibility because of the emphasis on employability. As shown in Figure 7.16, 61 percent of those with IU receive SSDI payments.

Figure 7.16 Percent with SSDI by Rating Group

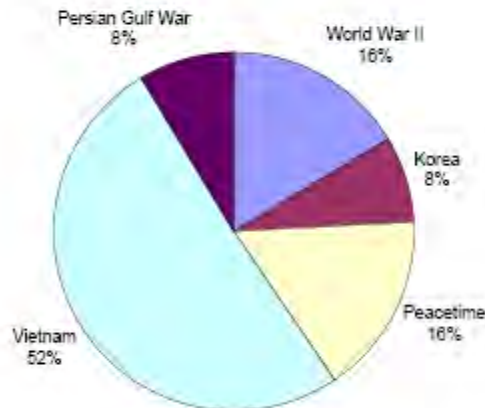


Source: CNAC, *Final Report*, Page 175.

II.3 IOM Highlights on IU

IOM investigated the issue of IU and reported its findings in *A 21st Century System for Evaluating Veterans for Disability Benefits*. In that report, IOM recognized that IU is one of the fastest growing segments within the VA Disability Compensation Program. There were 112,400 veterans receiving IU in FY 2000, but by the end of FY 2006, that number had more than doubled to 228,500 veterans.⁴⁹ IOM reported that 35 percent of IU beneficiaries have mental health conditions as their major diagnosis.⁵⁰ Of this group, two-thirds have PTSD. Outside of the mental health realm, 29 percent of the IU population has musculoskeletal conditions, and 13 percent have cardiovascular conditions.⁵¹ In addition, FY 2005 saw 38 percent of all IU beneficiaries at or above 65 years of age, 13 percent were between the ages of 60 and 64, and 49 percent were ages 59 and younger.⁵² In addition, as the shown in Figure 7.17, a large portion of the individuals participating in IU served during the Vietnam War Era.

Figure 7.17 IU recipients by period of service



Source: IOM, *21st Century System*, Page 234.

Several recommendations were made by IOM concerning what needed to be done to the IU program. IOM recommended the following:

⁴⁹ IOM, *21st Century System*, 189.

⁵⁰ *Ibid.*, 190.

⁵¹ *Ibid.*, 190.

⁵² *Ibid.*, 190.

- Medical evaluations should be done by medical professionals, and VA should require vocational assessment in the determination of eligibility for IU benefits.
- VA should monitor and evaluate trends in its disability program, and conduct research on employment among veterans with disabilities.
- Research should be conducted with service-connected disabled veterans who receive IU benefits past the normal age of retirement.
- IU should be based on the impacts of an individual's service-connected disabilities, in combination with education, employment history, and the medical effects of that individual's age on potential employability.
- A gradual reduction in compensation should take place when recipients are able to return to substantial gainful employment rather than abruptly terminating their disability payments at an arbitrary level of earnings.

The Commission carefully considered the findings of both IOM and CNAC and concluded that having medical evaluations performed by medical professionals trained to do them, reviewing vocational assessments by raters trained in reviewing them, updating the Schedule for Rating Disabilities to more equitably evaluate IU veterans, and a gradual reduction in compensation when the veteran is able to return to substantial work for a prolonged period of time will create an improved IU benefit reflective of the current medical, economic, and social scene.

Recommendation 7.4

Eligibility for Individual Unemployability (IU) should be consistently based on the impact of an individual's service-connected disabilities, in combination with education, employment history, and medical effects of an individual's age or potential employability. VA should implement a periodic and comprehensive evaluation of veterans eligible for IU. When appropriate, compensation should be gradually reduced for IU recipients who are able to return to substantially gainful employment rather than abruptly terminating disability payments at an arbitrary level of earning.

Recommendation 7.5

Recognizing that Individual Unemployability (IU) is an attempt to accommodate individuals with multiple lesser ratings but who remain unable to work, the Commission recommends that as the Schedule for Rating Disabilities is revised, every effort should be made to accommodate such individuals fairly within the basic rating system without the need for an IU rating.

III Compensating for Loss of Quality of Life

The Commission asked CNAC to study the health-related quality of life of veterans with disabilities and their survivors.⁵³ The Commission also asked IOM to assess whether the VA Rating Schedule takes into account loss of quality of life. CNAC's finding that service-connected veterans report lower quality of life than population norms and IOM's recommendations that VA compensate for loss of ability to function in activities of daily life and, if possible, loss of quality of life, are addressed in this section of the report.

III.1 CNAC Study of Quality of Life of Service-Connected Veterans

CNAC conducted a survey of a representative sample of service-connected veterans to collect data on their average quality of life. The survey included 20 questions from two widely used instruments for assessing health-related quality of life—12 questions from the Veterans RAND 12-Item Health Survey (VR-12) and 8 questions from the Veterans RAND 36-Item Health Survey (VR-36).⁵⁴ CNAC derived summary scores of physical health status and mental health status from the VR-12; these are the physical component summary (PCS) and mental component summary (MCS), which allowed them to compare service-connected veterans with established population norms in the published scientific literature. CNAC also calculated five additional subscales using the eight additional questions from the VR-36, which also have established population norms. The five subscales are: role physical, bodily pain, social functioning, role emotional, and mental health.

There are standard algorithms that are used to calculate the subscales and summary scores from each individual's response to the SF-12 and SF-36. The algorithms are designed to produce scores that can be used for comparisons across groups of people. When applied to data from the general U.S. population, the algorithms produce scores with means of 50 and standard deviations of 10. Note that higher scores mean better health. This means that a group with a mean score of 45 for a particular subscale or summary score has worse health on average than the general U.S. population.⁵⁵

⁵³ Survivors are addressed in Ch. 8.

⁵⁴ CNAC, *Final Report*, 64. The SF-12 and SF-36 were developed for use in the Medical Outcomes Study conducted in 1986-1992. The SF-36 is the most used health survey in the world. The SF-12 consists of 12 questions from the SF-36 that can explain almost all the variance in the SF-36's summary scores of physical and mental quality of life. Versions of the SF-12 and SF-36 have been developed specifically for use among veterans, called the VR-12 and VR-36.

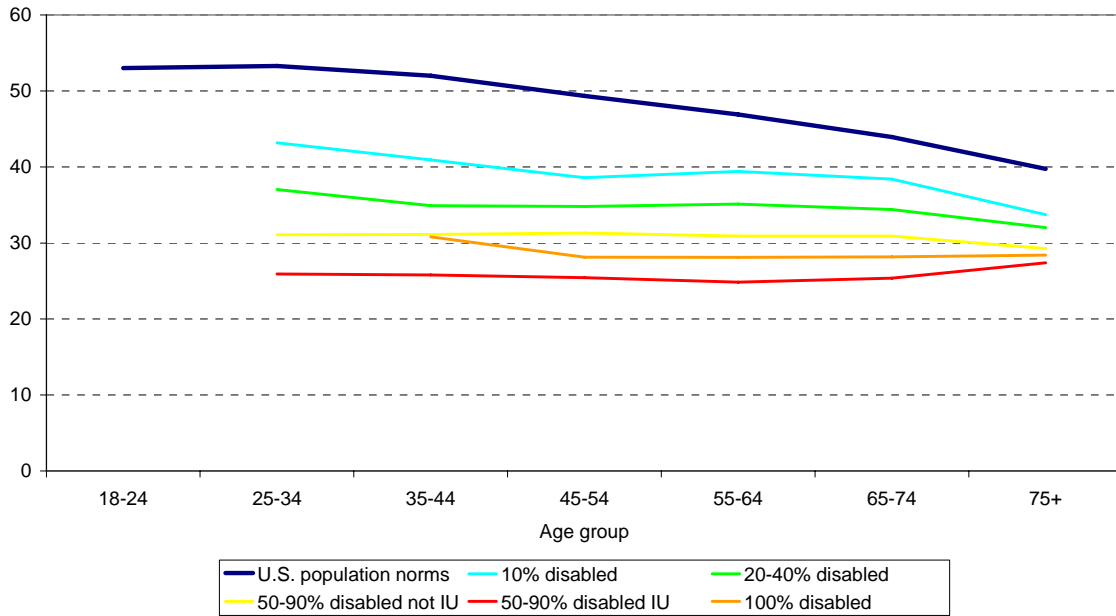
⁵⁵ CNAC, *Final Report*, 64.

The scores can be used to determine whether someone or a group, on average, has worse or better health-related quality of life compared to someone else or another group, but not how much better or worse. “Thus, if one group has an average score of 40 and another group has an average score of 42, we can say that health is better in the latter group, but we cannot say ‘how much’ better it is.”⁵⁶

CNAC found that service-connected veterans with primary physical disabilities have physical health status (PCS) scores below population norms at all disability levels, and that the scores generally declined as the rating percentage increased (Figure 7.18). Mental health status (MCS) scores of those with a primary physical disability were close to population norms except for veterans with the highest rating percentages, who had slightly lower mental health status scores (Figure 7.19).

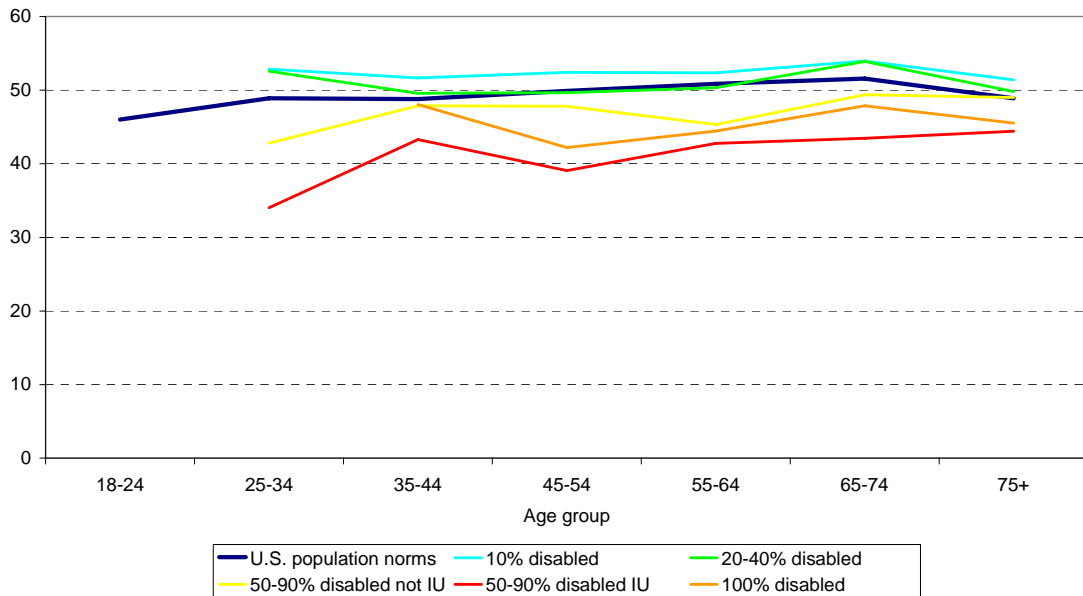
⁵⁶ Ibid.

Figure 7.18 PCS Scores of U.S. Population and Service-Connected Veterans with Physical Primary Disabilities, by Age Group



SOURCE: CNAC, *Final Report*, Page 68.

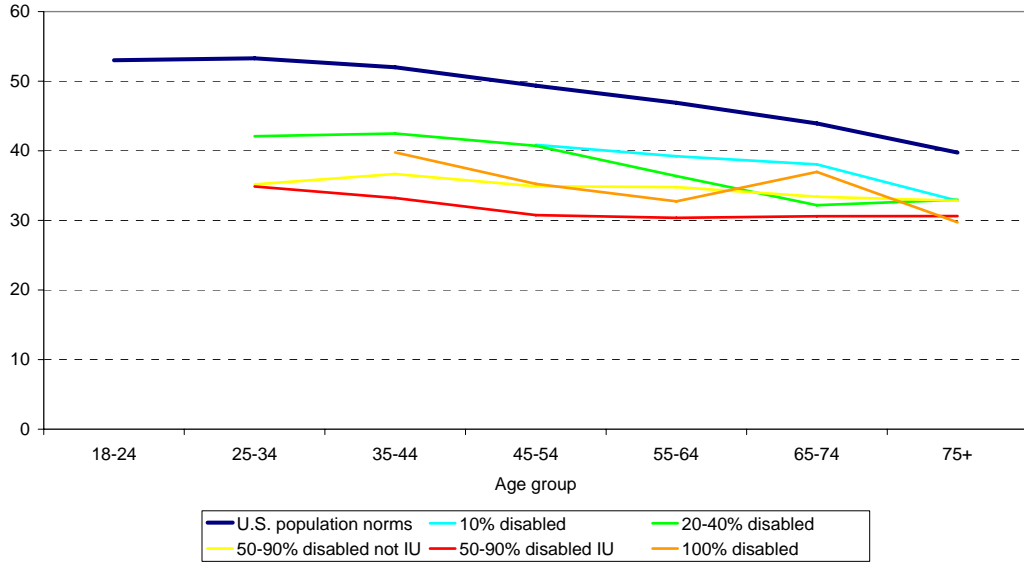
Figure 7.19 MCS scores of U.S. population and service-connected veterans with physical primary disabilities, by age group



SOURCE: CNAC, *Final Report*, Page 69.

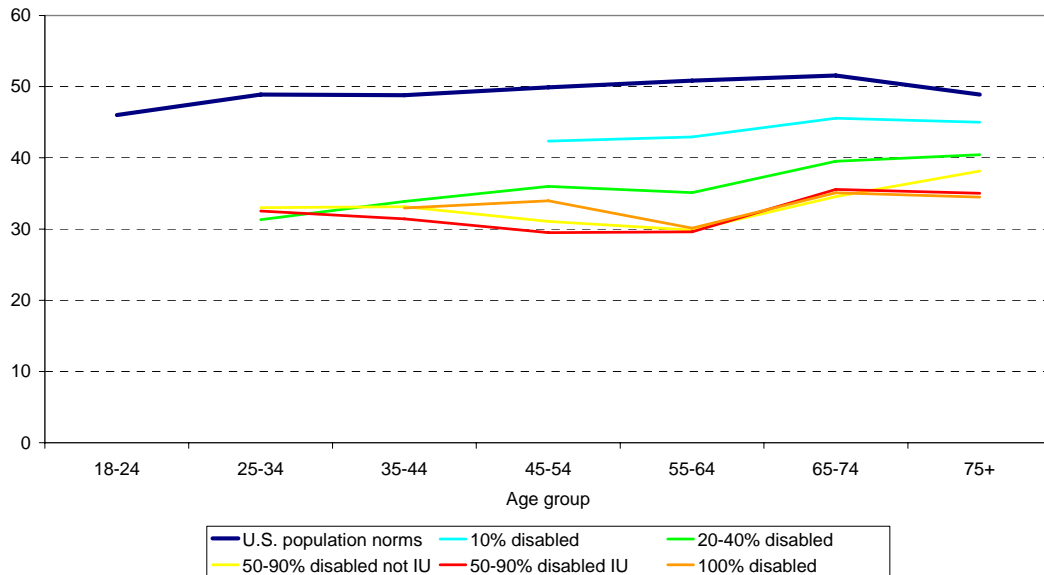
For service-connected veterans with primary mental disabilities, both physical health status and mental health status scores are well below population norms at every rating percentage (Figures 7-20 and 7-21).

Figure 7.20 PCS scores of U.S. population and service-connected veterans with mental primary disabilities, by age group



SOURCE: CNAC, *Final Report*, Page 70.

Figure 7.21 MCS scores of U.S. population and service-connected veterans with mental primary disabilities, by age group



SOURCE: CNAC, *Final Report*, Page 70.

CNAC summarized their major findings on health-related quality of life as follows:⁵⁷

- For those with a primary physical disability, there is a statistically significant impact on physical health as measured by the physical health status score (PCS) but not a significant impact of mental health as measured by the mental health status score (MCS) except for those with the highest percentage ratings.
- For those with a primary mental disability, there is a statistically significant impact on physical health and mental health for all rating groups as measured by the physical health and mental health status scores.
- The patterns for physical and mental health are consistent across physical body systems, and they are consistent among PTSD and other mental conditions.
- The patterns in the physical health and mental health status scores observed among veterans with a physical versus mental primary disability are similar for the physical and mental health subscales.
- The overall mental health of those with a physical primary condition was about the same as U.S. population norms, but scores on the social functioning subscale were significantly less, and this held for each of the physical body systems.
- Those rated 60–90 percent with IU status have physical and mental health status scores generally lower than those observed for veterans rated 100 percent according to the Rating Schedule (the IU data are not shown here, but the finding is addressed elsewhere in the discussion of IU).

The survey also asked veterans about the satisfaction they get from life overall. The analysis found that satisfaction went down as the rating percentage went up in all age groups. Satisfaction was generally less among veterans with primary mental disabilities than among those with physical primary disabilities.⁵⁸

CNAC's analysis of mortality rates reinforces the quality-of-life findings. They show that the Rating Schedule effectively sorts veterans by their state of health in the process of determining ratings. As the ratings increase, the mortality rate increases on average, which is consistent with the subjective assessments of service-connected veterans of their health-related quality of life. However, with respect to veterans with PTSD, mortality rates appear to be inconsistent with either quality-of-life findings or with earnings ratios. The mortality rates for veterans rated 100 percent PTSD are better than the rates for veterans rated 100

⁵⁷ CNAC, *Final Report*, 78, 79.

⁵⁸ *Ibid.*, 79.

percent not PTSD; similarly, the mortality rates for veterans rated IU PTSD are better than the rates for veterans rated IU not PTSD. Therefore, while the mortality rates indicate that veterans with PTSD are healthier than other veterans with comparable ratings, their quality-of-life ratings and earnings ratios are lower than other veterans with comparable ratings. It is possible that this reflects difficulty for veterans with PTSD to reintegrate into civilian life to the maximum extent possible.

III.2 IOM Study of Loss of Quality of Life

The IOM Committee on Medical Evaluation of Veterans for Disability Compensation made conceptual distinctions between *impairment*, *functional limitation*, and *work and nonwork disability*.⁵⁹ *Impairment* is the loss or partial loss of a physiological or anatomical structure (e.g., a lung or an arm) or loss or partial loss of a body function (e.g., limitation or loss of use of a knee or of lung capacity). *Functional limitation* refers to the extent to which a person is unable to engage in basic life activities because of impairments, such as dressing, eating, managing money, or walking across a room or up stairs. *Work and nonwork disability* result from the interaction of the person's functional limitations with environmental factors such as accommodations at work, availability of family support, and accessible transportation.

The IOM committee noted that the VA Rating Schedule is largely an impairment rating schedule, not a schedule for rating disability. For other than mental ratings, it does not consider the ability of the person to function in life. Other than the inclusion of some disabilities that clearly have little or no impact on ability to work, the schedule does not consider quality of life. The use of the schedule is based on the assumption that degree of impairment and its social and economic consequences (i.e., disability) are roughly related, on average. The IOM committee concluded that impairment rating does not capture the full scope of disability in many cases and recommended that VA compensate for functional limitations on usual life activities and for loss of quality of life, to the extent that the Rating Schedule does not account for them already.⁶⁰

IOM Recommendation 4-5: VA should compensate for nonwork disability, defined as functional limitations on usual life activities, to the extent that the Rating Schedule does not, either by modifying the Rating Schedule criteria to take account of the degree of functional limitation or by developing a separate mechanism.

⁵⁹ IOM, *21st Century System*, Ch. 3.

⁶⁰ IOM, *21st Century System*, 104.

IOM Recommendation 4-6: VA should determine the feasibility of compensating for loss of quality of life by developing a tool for measuring quality of life validly and reliably in the veteran population, conducting research on the extent to which the Rating Schedule already accounts for loss in quality of life, and if it does not, developing a procedure for evaluating and rating loss of quality of life of veterans with disabilities.

The Commission has a broader view of the quality-of-life domain than IOM. In the scientific literature, health-related quality of life is measured with scales based on subjective self-reporting of subjects and is different from clinician assessments of an individual's ability to carry on a normal life. For compensation purposes, the Commission has interpreted quality of life to include the nonwork aspects of disability, encompassing how well someone can function in everyday life *and* how they feel about their situation. Both these aspects of disability are addressed in this section of the report.

CNAC has established that the quality of life of service-connected veterans is significantly lower than the quality of life of the general population, on average, and that average quality of life becomes less and less as rating percentages increase. IOM finds that functional limitations and loss of quality of life of individuals are aspects of disability in addition to impairment, and recommends that VA compensate for them if possible, to the extent that the medically based Rating Schedule does not do so.

The basis for this distinction [between work and nonwork disability] is that a veteran may be working but unable to participate in other usual life activities. For example, a veteran may be employed in a good job but suffer from the symptoms of PTSD. A veteran with severe mobility restrictions might be able to use a computer linked to the Internet to earn a good living from home, especially if there are adequate social supports (e.g., friends or family to help with food shopping). There are many ways in which the lives of veterans with service-connected injuries and diseases can be changed by the effects of [those] injuries or diseases.⁶¹

According to IOM, one approach VA could take would be to perform functional assessments of service-connected veterans using well-established scales such as activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Or VA could use condition-specific functional scales, although IOM notes that achieving parity across conditions might be a challenge. Validated

⁶¹ IOM, *21st Century System*, 103.

functional assessment instruments have been developed for most conditions; the IOM report cites the following:

- Extended Glasgow Outcome Scale and Community Integration Questionnaire for brain injury
- National Institutes of Health Stroke Scale for stroke
- Functional Independence Measure and Spinal Cord Independence Measure for spinal cord injury
- St. George's Respiratory Questionnaire
- Guyatt's Chronic Respiratory Questionnaire
- University of California at San Diego Shortness of Breath Questionnaire for chronic obstructive pulmonary disease
- Diabetes Health Profile for diabetes

The next step would be to apply these assessments to representative groups of veterans to see if the current Rating Schedule already accounts for functional limitations to a reasonable degree. This would be the case if, in a given condition, functional limitation scores tend to increase in step with rating percentages, on average. If this is not the case, then veterans are not being compensated for the full extent of their disabilities, just for loss or loss of use of a limb or organ.

IOM recommends that, if VA finds that the Rating Schedule does not adequately account for nonwork disabilities, it should find a way to compensate for it. One way might be to incorporate functional measures in the Rating Schedule criteria, which is the direction that the American Medical Association is taking with the next edition of its *Guides to the Evaluation of Permanent Impairment*, which is widely used to measure impairment in workers' compensation and private disability insurance programs. The Listing of Impairments used by the Social Security Disability Program as its medical screening tool has been moving toward functional assessment for some time, for example, looking at the ability of someone with a musculoskeletal impairment to ambulate effectively rather than at the limitation of motion of the affected body part.

The IOM report mentioned several other methods of compensating for loss of quality of life, which are based on assessments of a veteran's ability to function:

1. The Canadian veterans' compensation program, for example, evaluates ability to participate in three functional areas: activities of independent living, participation in recreational and community activities, and initiation of and participation in personal relationships. These are graded on a scale ranging from mild limitations or reductions of ability, moderate

interference, and extreme inability to carry out each of the three functions. These are combined in a table to generate a quality-of-life rating ranging from 1 to 20 percentage points that is added to the impairment rating percentage to form the disability assessment.

2. The Australian Department of Veterans' Affairs determines an impairment rating between 5 and 100 percent using a rating schedule. Then it determines a "lifestyle rating" based on the extent an individual is limited in fulfilling roles filled by normal veterans without a service-connected injury or disease. The lifestyle rating is an average of ratings on four scales—personal relationships, mobility, recreational and community activities, and employment and domestic activities. The impairment rating and lifestyle rating are then combined using a table into the percentage used to determine the amount of compensation—the compensation factor. In Australia, the lifestyle rating can account for 15 percent of the compensation factor for impairment ratings up to 50 percent and less for higher impairment ratings. In addition, for severe conditions that leave veterans bedridden or housebound, or because of severe stroke, Parkinson's disease, heart failure, respiratory failure, liver failure, severe kidney failure, and some dementias, ADLs are evaluated using one scale and nonspecific indicators of disease such as pain, lethargy, and poor prognosis are assessed on another scale. The higher of the two scores is compared with the traditional body-system-based impairment rating, and the higher of those two ratings is used to determine the amount of compensation.⁶²

There are two basic approaches to measuring subjective health-related quality of life. One is to use psychometric scales such as the VR-12 or VR-36. These are well established and widely used, and research has shown that the quality-of-life scores of participants in medical research, such as clinical trials, can be a better predictor of outcomes than clinical diagnoses. The problem with psychometric scales is that they cannot be converted into ratings. As CNAC explained in reporting on its analysis of the quality-of-life survey of veterans, the physical and mental health status or other scores based on the VR-12 and VR-36 can identify who has worse health but cannot be used to quantify how much worse.⁶³

The other approach to measuring quality of life is an economic utility-based evaluation by a representative sample of a population of the percentage impact of a given condition on quality of life. Examples of these quality-of-life scales are the Quality of Well-Being Scale and EuroQol-5D, for which the utilities or preferences of the U.S. population have been determined. It would be possible to determine the preferences for a VA population. According to IOM, this approach has the promise of translating quality-of-life population norms for

⁶² IOM, *21st Century System*, 68–69, 103–104.

⁶³ CNAC, *Final Report*, 64.

disabling conditions directly into rating percentages, but much work needs to be done to perfect the scales and develop the norms. The approach would not involve applying quality-of-life scales to each service-connected veteran; rather, norms would be set by having a relevant population, in this case, probably a representative sample or samples of military veterans or service members, decide how much quality of life they think they would lose if they suffered particular injuries, say, permanent loss of vision in an eye. Then VA could see if such studies show that the loss of quality of life is substantially more extreme than the impairment rating would indicate for some disabling conditions.

Quality-of-life assessment is relatively new and still at a formative stage, which makes implementation of Recommendation 4-6 more long term and experimental. HRQOL [health-related quality of life] instruments are the most developed and validated. VHA already uses a psychometric HRQOL instrument, the SF-36, to assess the effectiveness of medical interventions, and it has been adapted and validated for the population of veterans receiving care in an ambulatory setting (SF-36V). Preference-based HRQOL instruments are less well developed but have the potential to be more useful in a compensation system, because the results can be quantified and located on an interval scale (the SF-36V does not, for example, provide a summary score).

VA should begin a program of empirical research and development to determine the quality-of-life effects of service-connected injuries and diseases. The goal would be to see if a global HRQOL instrument could reliably and validly measure the quality of life of disabled veterans and be the basis for compensating for loss of quality of life. A preference-based HRQOL measure would also have to place values on losses that veterans and the remainder of the community agree on, so that compensation based on HRQOL losses would be acceptable to both groups. While it is not clear, based on the current status of the science, that it is possible to measure HRQOL with a significant degree of accuracy, the committee believes there is a good chance this goal can be achieved and, because of its importance, should be attempted.⁶⁴

The Commission agrees with the IOM recommendation that VA launch a research and development effort on quality-of-life measurement tools or scales and study ways to determine the degree of loss of quality of life, on average, of disabling conditions in the Rating Schedule. If this effort is successful, VA should

⁶⁴ IOM, *21st Century System*, 108. The SF-36V has been renamed the VR-36.

analyze whether there are conditions in which the loss of quality of life is much worse than the average rating percentage and, if so, compensate for it.

The Commission recognizes that the President's Commission on Care for America's Returning Wounded Warriors (PCCARWW) also recommended a quality-of-life payment and agrees with their position.

The Commission believes that disabled veterans should not wait for extensive research to be completed; rather, an interim approach should be quickly developed to compensate veterans for the impact of their service-connected disabilities on their quality of life in the near term.

Recommendation 7.6

Congress should increase the compensation rates up to 25 percent as an interim and baseline future benefit for loss of quality of life, pending development and implementation of a quality-of-life measure in the Rating Schedule. In particular, the measure should take into account the quality of life and other non-work-related effects of severe disabilities on veterans and family members.

Recommendation 7.7

Congress should create a severely disabled stabilization allowance that would allow for up to a 50 percent increase in basic monthly compensation for up to 5 years to address the real out-of-pocket costs above the compensation rate at a time of need. This would supplement to the extent appropriate any coverage under Traumatic Servicemembers' Group Life Insurance.

Recommendation 7.8

Congress should consider increasing special monthly compensation, where appropriate, to address the more profound impact on quality of life of the disabilities subject to special monthly compensation. Congress should also review ancillary benefits to determine where additional benefits could improve disabled veterans' quality of life.

IV DoD Disability Evaluation System

The Disability Evaluation System (DES) is the process by which each of the military branches determines whether or not a service member is fit to perform

the duties of his or her office, grade, rank, or rating because of disease or injury.⁶⁵ The process begins with a medical evaluation board (MEB) that reviews the service member's impairment and makes a determination of fitness for duty. If the service member is not returned to duty, the process continues with a physical evaluation board (PEB). The PEB convenes with a three-member board (one or two medical officers and one or two line officers) who will decide if the service member can perform his or her military duty, and if not, determines a level of disability using the VA Schedule for Rating Disabilities (VASRD). The DES process is governed under 10 U.S.C. chapter 61 and by DoD Instruction 1332.39.⁶⁶ The Army, Navy/Marines, and Air Force each have their own directives governing the application of the DoD instruction and convene MEB and PEBs differently, based on their needs. The Commission heard criticisms regarding inconsistencies between these ratings and with VA, which led to its conducting a literature review and contracting with CNAC to find the following information.

In March 2006, the Government Accountability Office (GAO) reported on the DES and found that the Army, Navy/Marines, and Air Force's policies and procedures for disability evaluations and determinations were different. GAO attributed these dissimilarities to the lack of DoD direct implementation of its policies and guidelines. According to the GAO, "DoD has explicitly given the services the responsibility to set up their own processes for certain aspects of the Disability Evaluation System."⁶⁷ This freedom has led to the independent and somewhat different interpretation and application of the DES in each of the service branches.⁶⁸ Although DoD is providing guidance to help promote consistent, efficient, and timely disability decisions for both the active duty and reservists' disability cases, it is not monitoring compliance, accountability, effectiveness, or accuracy in the decision-making process. There is no DoD-wide database, and this prevents standardization among the branches.

GAO found that there were serious problems and inconsistencies in the electronic data. GAO attributed this disparity to the lack of systematic training and oversight by DoD, and an inadequate system for adding additional information from medical tests to the narrative summary.

This also has implications in the development of a VA/DoD medical data sharing system as it precludes the determination of accurate, useful, medical data, which would be required for expeditious and objective disability decisions. The inaccuracies of the DoD data also raises concerns over disability information

⁶⁵ Howard, *DoD DES Exam Process*.

⁶⁶ *Ibid.*

⁶⁷ GAO, *Military Disability System*, 1.

⁶⁸ *Ibid.* See this report for a detailed description of the medical and physical evaluation boards stages of the disability process.

sharing with VA as both Departments' disability compensation evaluation systems still need significant and relevant modifications.⁶⁹

An assessment of the disability processing time could not be conducted by GAO because the data in the Army's electronic databases were deemed unreliable.⁷⁰ GAO also found that disability ratings for reservists with comparable injuries or illness to those of the active duty were not the same, and that the level of compensation was less. The reasons why these disparities were found are not clear because of limited and unreliable information that impedes an assessment of this issue. There were several observations and recommendations that came from the March 2006 GAO report that could be further explored and implemented to improve the DES:

1. Disability Advisory Council (DAC): DoD periodically convenes DAC meetings with branch officials to review and update disability policy and discuss current issues. However, neither DoD nor the branches systematically analyze the consistency of decision making. The time and effort put forth in these meetings produces limited results because the branches are unwilling to change policies. However, if they were better aligned, a more objective analysis of the DES could be conducted. GAO indicated that, "such an analysis of data should be one key component of quality assurance."⁷¹ GAO further noted, "DoD is not collecting available information on disability evaluation processing time from the services to determine compliance, nor are they ensuring these data are reliable."⁷² Consequently, inefficiencies and errors in data collection, such as missing information and the inaccuracy of data entered, need to be corrected. Therefore, GAO concluded that increasing DAC meetings in frequency and duration would allow DoD to correct some of the limitations in the current DES. This would require having personnel from all parties involved (DoD, the branches, and VA) in the DES working as full-time members on the DAC.
2. Misinformation of functions and responsibilities: Internal communication and misunderstanding is a significant concern. GAO stated, "Despite a regulation requiring DoD's Office of Health Affairs (HA) to develop relevant training for disability staff, DoD is not exercising oversight over training for staff in the disability system."⁷³ HA indicated, "They were unaware that they had the responsibility to develop a training program."⁷⁴ In addition, this issue is heightened by the high turnover rate of military disability

⁶⁹ GAO, *Veteran's Disability Benefits*,

⁷⁰ GAO, *Military Disability System*, 1.

⁷¹ *Ibid.*, 3.

⁷² *Ibid.*

⁷³ *Ibid.*, 4.

⁷⁴ *Ibid.*, 22.

- evaluation staff, plus the branches do not have a comprehensive or well-developed plan to ensure that all staff are properly trained. A clearer delineation of responsibility and communication of duties for each DoD office is required to eliminate any confusion in these areas.
3. DoD lack of oversight and consistent guidance: There is concern with the inconsistency of the DES across the branches and lack of DoD involvement. GAO noted that in some cases the current time-processing goals were unrealistic. An assessment of a realistic timeline for processing disability cases is needed. HA needs to take charge of training by developing, implementing, and evaluating training for all of the branches.

Based on these findings, GAO made five recommendations:

1. Require branches to ensure that data to assess consistency and timeliness of military disability ratings and benefit decisions are reliable.
2. Require the branches to track and regularly report these data including comparisons of processing times, ratings, and benefit decisions for reservists and active-duty members to the Under Secretary of Personnel and Readiness and the Surgeons General.
3. Determine if ratings and benefit decisions are consistent and timely across the branches, between reservists and active-duty members, and institute improvements to address any deficiencies.
4. Evaluate the appropriateness of current timeliness goals for the disability process and take appropriate actions.
5. Assess the adequacy of training for MEB and PEB disability evaluation examiners.⁷⁵

According to GAO, “to encourage consistent decision making, DoD requires all branches to use multiple reviews to evaluate disability cases. Furthermore, federal law requires that reviewers use a standardized disability rating system to classify the severity of the medical impairment.”⁷⁶ Nevertheless, “each of the services administers its own disability evaluation system and assigns a standardized severity rating from 0 to 100 percent, to each disability condition, which along with years of service and other factors, determines compensation.”⁷⁷ However, “despite this policy guidance and the presence of the disability council, DoD and the three service branches lack quality assurance mechanisms to

⁷⁵ GAO, *Military Disability System*, 27, 28

⁷⁶ *Ibid.*, 1.

⁷⁷ *Ibid.*

ensure that decisions are consistent.”⁷⁸ Plus, each branch has developed its own instruction on the VA Schedule for Rating Disabilities.⁷⁹

DoD and VA need to assess the differences in the application of the Rating Schedule. The Congressional Commission documented that “the two systems apply different standards because they make determinations for different purposes.”⁸⁰ The report recommended that, “a combined DoD/VA Disability Evaluation Rating Board would avoid redundancy.”⁸¹ This coordination of efforts could make sure that both military service members and veterans are receiving a consistent disability rating and compensation. At the SIMS meetings, it has been suggested that this process could include the Social Security Administration for SSDI determinations as well.

In April 2007, the Independent Review Group (IRG) on the Rehabilitative Care and Administration Processes at Walter Reed Army Medical Center and National Naval Medical Center supported the findings of several GAO studies and the President’s Task Force to Improve Health Care Delivery for Our Nation’s Veterans, and observed that “there are serious difficulties in administering the Physical Disability Evaluation System (PDES) due to a significant variance in policy and guidelines within the military health system. There is much disparity among the services in the application of the PDES that stems from ambiguous interpretation and implementation of a Byzantine and complex disability process.”⁸² The IRG concluded that titles 10 and 38 should be amended to allow “the fitness for duty determination to be adjudicated by DoD and the disability rating be adjudicated by VA,”⁸³ and that the Departments should implement the single physical exam process as described by GAO.⁸⁴ The IRG also recommended that the DAC be expanded.

The Task Force on Returning Global War on Terror Heroes recommended that “VA and DoD develop a joint process for disability determinations.”⁸⁵ They described a similar process by which the Departments would cooperate in assigning a disability evaluation that would be used to determine fitness for retention, level of military retirement, and VA compensation, and be undertaken as an expansion of the Benefits Delivery at Discharge (BDD) Program for all MEB and PEB service members.⁸⁶

⁷⁸ GAO, *Military Disability System*, 19.

⁷⁹ DoD, Instruction 1332.39.

⁸⁰ Congressional Commission, *Report*, 139.

⁸¹ *Ibid.*

⁸² Independent Review Group, *Rebuilding the Trust*, 28.

⁸³ *Ibid.*, 30.

⁸⁴ *Ibid.*, 34.

⁸⁵ Task Force on Returning Global War on Terror Heroes, *Report to the President*, 21.

⁸⁶ *Ibid.*, 23.

V Consistency of Disability Ratings between DoD and VA

The Commission became concerned with the consistency of disability ratings between DoD and VA because of the findings of a 2002 RAND study, a 2006 GAO report assessing the DoD Disability Evaluation System (DES), and anecdotal evidence of inconsistencies that individual members of the public presented to the Commission.

In a 2002 study, RAND “identified 43 issues regarding variability in policy application across or within the military departments...that affect the performance of the DES.”⁸⁷

Four years later, GAO released a study that found multiple flaws in DoD’s methods for rating disabilities. GAO found that DoD delegates responsibility for assigning disability ratings to the services (Army, Navy, and Air Force) and does not maintain accountability for or monitor compliance with DES. The services are allowed to establish different time frames for line-of-duty determinations, medical evaluation board (MEB) referrals, MEB compositions, MEB appeals, physical evaluation board (PEB) responsibilities and compositions, and training. GAO found an absence of consistency in the training of staff who serve on MEBs and PEBs, and as counselors. GAO also found that there is no common DoD database that tracks disabled service members; moreover, each service’s database for such tracking is different.⁸⁸

Individuals testifying before the Commission alleged that VA ratings were generally much higher than DoD ratings. No analysis of actual differences in ratings could be found.

V.1 Analysis of DoD and VA Ratings by CNAC

In response to this information, the Commission contracted with CNAC to compare DoD rating decisions with VA ratings and assess their consistency. CNAC received 83,004 records from the Army, Navy, and Air Force on all disability separations and disability retirements from 2000 through 2006, and these data were compared with data from VA on all 2.6 million veterans receiving

⁸⁷ RAND, *Methods and Actions*, 85–89.

⁸⁸ GAO, *Military Disability System*, 3, 4.

disability compensation as of December 1, 2005. Records were not requested from the services regarding those who were separated as unfit but were found to have preexisting conditions. Results of the analysis appear below.

The disability ratings shown in Table 7.5 are the combined or overall ratings assigned by DoD to those individuals who were found unfit for military duty. Those with less than 20 years of service and who are rated less than 30 percent disabled receive a severance payment based on base pay and years of service, but no continuing retirement payment. They are not eligible for Tricare coverage for themselves or their families and receive no other benefits from DoD. As can be seen, overall 19 percent of those rated by DoD are in the 30–100 percent range. The percentage rated 30 percent or higher ranges from 13 percent for the Army to 36 percent for the Navy. The individuals rated 30 percent or higher will receive continuing military disability retirement, health care coverage for themselves and their families, and many other military retirement benefits.

Table 7.5 Veterans with DoD disability ratings (2000-2006)

COMBINED DISABILITY RATING	ARMY	NAVY	MARINES	AIR FORCE	TOTAL
0-20%	44,307 (87%)	8,606 (64%)	7,770 (82%)	6,862 (73%)	67,545 (81%)
30-100%	6,369 (13%)	4,849 (36%)	1,748 (18%)	2,497 (27%)	15,463 (19%)
Total	50,676	13,455	9,518	9,359	83,008

SOURCE: CNAC, *Final Report*, Page 179.

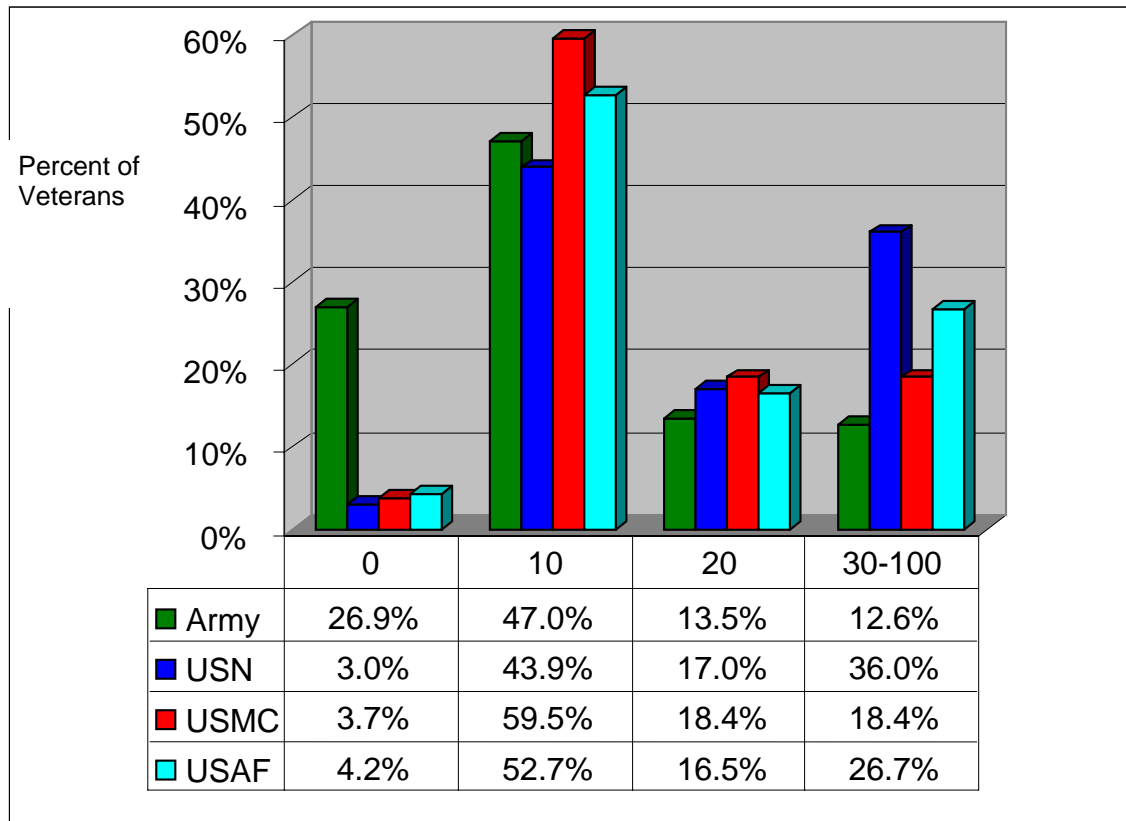
The Army data contained 13,646 records (27 percent) out of the total of 50,676 service members who were found unfit for duty yet assigned zero percent ratings. The Navy, Marine Corps, and Air Force each assigned zero percent ratings to about 400 individuals or less. The Army explained that these service members were found unfit, but with symptoms whose severity did not qualify for a compensable rating of at least 10 percent. Whether the DoD rating is zero, 10, or 20 percent, the severance payment from DoD is the same. Among the Army’s zero percent ratings that matched with VA records, the average VA disability rating was 56 percent for those with 20 or more years of service and the average was 28 percent for those with less than 20 years of service and receiving severance.

It is important to note that DoD policy requires that the services only rate the condition or conditions that the services find make the individual unfit for duty.

This policy differs from that of the past. Before 1986, DoD instructions required that all service-connected conditions be rated, regardless of whether the condition(s) contributed to an unfit determination, with the exception of hysterectomies.⁸⁹ But on the basis of a DoD General Counsel opinion dated March 25, 1985, the policy changed to the present standard of rating only conditions that render service members unfit for duty.⁹⁰ Currently, when determining the disability ratings, the services are no longer required to rate a condition if that condition does not render the service member unfit for military duty. Consequently, the services rated only one condition 83 percent of the time.

The proportion of ratings in the 30–100 percent range given to Navy personnel, and, to a lesser extent, Air Force personnel is significantly greater than the proportion of ratings in the 30–100 percent range given to Marines and Army personnel (Figure 7.22). This observed difference is counterintuitive because the Army and Marines have borne the brunt of the combat in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). The available data were insufficient for the Commission to determine the reasons for the variance.

Figure 7.22 Distribution of Veterans by DoD Disability Rating



⁸⁹ DAPD-PP, 29 January 1986.

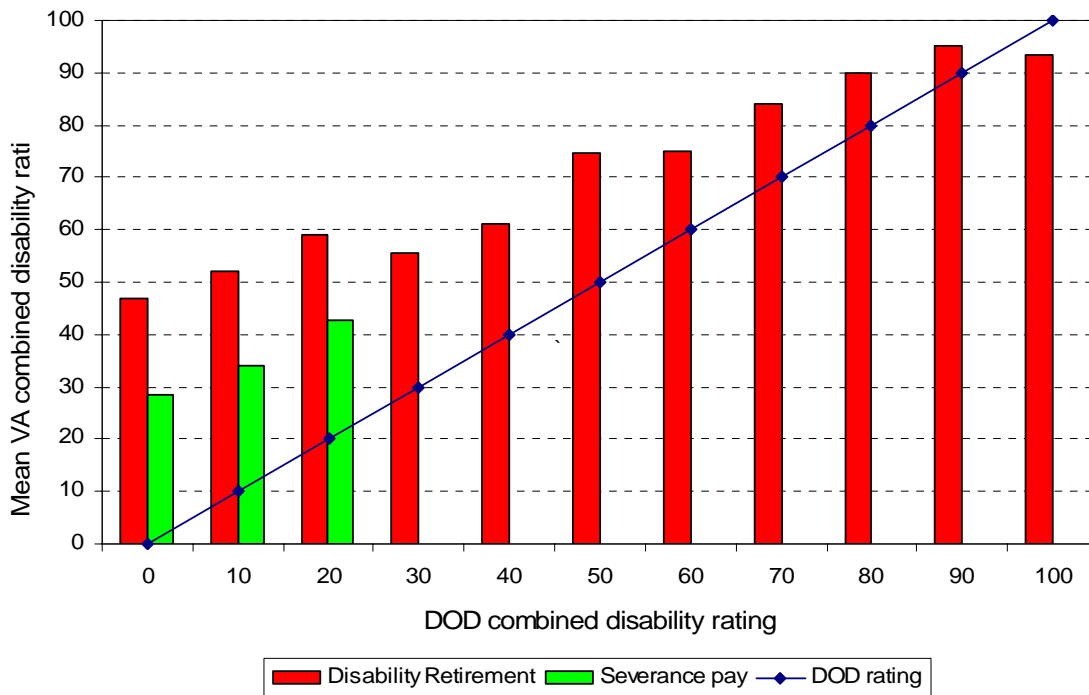
⁹⁰ DoDI 1332.18 (Enclosure 5, A2b) February 25, 1986.

Source: CNAC, *Final Report*, Page 179

Upon matching military service records with VA records, CNAC found that 79 percent of the service members rated by the military had also received disability ratings from VA.

As illustrated in Figure 7.23, the combined disability ratings made by VA are higher, on average, than the combined ratings made by the services at almost all rating levels. Individuals who received ratings of less than 30 percent and who had fewer than 20 years of service received severance pay only. Individuals assigned a zero percent rating by the services received, on average, a 30 percent rating from VA. Individuals rated 30 percent by the services were rated an average of 56 percent by VA. The difference between VA and DoD ratings is even more pronounced for those individuals rated less than 30 percent by DoD but eligible for retirement with 20 or more years of service, as represented by the first three red bars on the left of the chart.

Figure 7.23 Comparison of Average VA Disability Ratings with DoD Disability Ratings



NOTE: The data in this figure is based on records of 65,500 service members. The red and green bars measure the mean VA combined disability rating levels. The green bars represent service members who received VA disability ratings of less than 30 percent, had fewer than 20 years of military service, and therefore received severance pay but not disability retirement pay.

SOURCE: CNAC, *Final Report*, Page 182.

Among individuals whom the services rated as zero, 10, or 20 percent disabled, VA rated them 30 percent or higher 61 percent of the time.

The number of conditions that VA rated differs significantly from the number rated by the services (Table 7.6). Moreover, in cases where the Services rated one condition, CNAC found that VA rated an average of 3.8 conditions. In general, VA rated 2.4 to 3.3 more disabilities than did the Services. CNAC believes that this difference in the number of conditions rated accounts for the largest proportion of the difference in overall ratings by the Services compared with VA.

Because of the difference in the number of conditions rated, it is important to compare the ratings assigned by the services with the VA ratings for the same disabilities experienced by the same veterans.

CNAC analyzed the seven most frequent diagnoses among 31,473 matches of individual diagnoses that it identified. Those diagnoses are the following:

- Lumbosacral or cervical strain
- Arthritis
- Intervertebral disc syndrome
- Asthma
- Diabetes
- Knee impairment
- Posttraumatic stress disorder (PTSD)

Six other diagnoses among the 20 most frequent diagnoses were also selected:

- Traumatic brain injury
- Migraine
- Seizure disorder
- Bipolar disorder
- Major depressive disorder
- Sleep apnea

Table 7.6 Number of VA Disabilities v. Number of DoD Disabilities

Number of DoD Disabilities	Number of Veterans	Average Number of VA Disabilities	VA-DoD Difference
Army			
1	32,356	3.8	2.8
2	6,031	5.3	3.3
3	1,170	6.4	3.4
4	329	7.1	3.1
Navy			
1	9,182	3.9	2.9
2	1,337	5.4	3.4
3	335	6.3	3.3
4+	143	7.1	3.1
Marine Corps			
1	6,392	3.7	2.7
2	707	5.4	3.4
3	140	6.1	3.1
4+	62	7.1	3.1
Air Force			
1	5,248	4.3	3.3
2	1,636	5.0	3.0
3	433	5.9	2.9
All Services			
1	53,178	3.8	2.8
2	9,711	5.3	3.3
3	2,078	6.3	3.3
4+	534	7.1	3.1

Note: The Army data caps the number of disabilities at four and the Air Force, at three. The Air Force data contains only a single, combined percentage rating, so records with more than one disability could not be considered in the analysis of individual disabilities.

SOURCE: CNAC, *Final Report*, Page 186.

Together, these 13 diagnoses comprise 19,397, or 62 percent, of the individual diagnoses matched. Detailed information on the comparison of the 13 diagnoses can be found in Appendix G of this report.

Among those 19,397 individual diagnoses, CNAC found that 72 percent of those rated 0–20 percent by the services were also rated 0–20 percent by VA. This demonstrates general agreement between VA and the services in the rating of individual diagnoses. In some cases the VA rating was lower, but more often VA was higher.

The DoD DES provides instructions for using the VA Rating Schedule that, in effect, change the criteria for rating many conditions. For example, DoD instructions regarding sleep apnea profoundly change the criteria. CNAC found that the services rated 107 of 123 cases of sleep apnea as zero percent disabling, yet unfit. Meanwhile, VA rated all 107 cases in the 30–100 percent range, with 105 rated at 50 percent, one at 30 percent, and one at 100 percent. For some conditions such as knee impairment, DoD criteria are more specific and more measurable than VA criteria, while for other conditions such as sleep apnea, DoD criteria are less specific and less measurable.

Of the 13 individual diagnoses analyzed, the VA ratings were statistically significantly higher than the ratings of all of the services for 10 diagnoses: lumbosacral or cervical strain, intervertebral disc syndrome, asthma, sleep apnea, diabetes, migraine, seizure disorder, PTSD, bipolar disorder, and major depressive disorder (Table 7.7). The differences in ratings were significant for 12 of 13 diagnoses by the Army; the only exception being the knee. The ratings were significantly different for 11 of the 13 diagnoses by the Air Force, 10 of 13 diagnoses by the Marines, and 9 of 13 diagnoses by the Navy.

Table 7.7 Statistical Significance of Individual Diagnoses

DIAGNOSIS	DIFFERENCE BETWEEN VA AND DOD IS STATISTICALLY SIGNIFICANT*			
	Army	USAF	USMC	Navy
Arthritis	√			
Lumbosacral or Cervical Strain	√	√	√	√
Intervertebral Disc Syndrome	√	√	√	√
Knee Condition				
Asthma	√	√	√	√
Sleep Apnea	√	√		√
Diabetes	√	√		√
Traumatic Brain Injury (TBI)	√	√		
Migraine Headaches	√	√	√	√
Seizure Disorder	√	√	√	√
PTSD	√	√	√	√
Bipolar Disorder	√	√	√	√
Major Depressive Disorder	√	√	√	√
*Check marks indicate that the mean VA rating is statistically higher than DoD's rating at the 5-percent level.				

SOURCE: CNAC, *Final Report*, Page 190.

V.2 Why are DoD and VA Ratings Different?

The difference between DoD and VA combined or overall ratings is most likely due to variance in the number of conditions rated. VA rates 2.4 to 3.3 more conditions per person than do the services. The difference in the individual diagnosis ratings also contributes to the difference in the combined ratings. VA ratings for 8 of 13 individual diagnoses were higher by a statistically significant amount than ratings by the services for the same individuals. Finally, there appears to be some incentive on the part of the services to assign ratings less than 30 percent so that only separation pay is required and continuing family health care and other retirement benefits are not provided. This incentive is reflected in the DoD policy decision in 1986 to begin rating only the condition(s) found to be unfitting.

V.3 Findings

VA and the services face challenges to improve the quality and consistency of rating veterans and service members for disability. Service members are poorly

served by the dual processes by which both the military services and VA evaluate disabilities and award benefits. Additionally, service members find these processes to be confusing and adversarial. The President's Commission on Care for America's Returning Wounded Warriors also advocated for the complete restructuring of the DES (with VA) to eliminate parallel activities, reduce inequities, and allow injured veterans to return to living more productive lives.⁹¹ This Commission believes that both short- and long-term changes are needed to ensure equity, effectiveness, consistency, and efficiency.

The Commission finds it unfair to discharge service members with ratings that reflect only one disability when other disabilities are present, identified, and often more severe than the disabilities that made the service member unfit according to the services. This is particularly true in cases where the Army categorized service members as unfit, but at a zero-percent rating. In addition, the current policy in which service members can be found unfit due to preexisting conditions with up to 8 years of active duty and separated with no compensation is an unreasonably long period of time, especially if the service member has served combat tours.

Fitness for duty is the most important issue to the services. Each service has unique manpower needs to meet its mission. A service member's ability to perform his or her military occupational specialty based on the service member's "office, grade, rank, or rating"⁹² should continue to be evaluated for the needs of the service. Currently, the MEB determines fitness for duty. The services can find someone fit and either return him or her to full duty, or issue a "profile" that limits duty. If a service member is found unfit, a PEB assigns a disability rating.

The Commission believes that the responsibility for assigning a disability rating should be turned over to VA and that the MEB/PEB structure should be streamlined. These changes would give each service member a single, objective rating that would apply to military disability retirement pay or severance pay as well as VA disability compensation. In essence, such changes would expand the Benefits Delivery at Discharge Program that VA has implemented and would relieve the services of the burden of making rating decisions. The disability rating should be completed prior to discharge to maintain continuous financial support and health care for separating service members.

Key to this realignment would be the development and implementation of a single, comprehensive medical examination protocol that would be used by both the services and VA. This protocol would require examining all conditions that

⁹¹ President's Commission on Care, *Report*, 5.

⁹² DoD Instruction 1332.35, paragraph E.2.1.21, July 10, 2006.

were found on exam, and not be restricted to the “unfitting” conditions. Service members would not be subjected to multiple examinations. It might be appropriate for the examinations to be conducted by VA medical staff at some locations and by DoD staff at others. Training and certification of all examiners will be essential for consistent, high-quality examinations.

The Commission realizes that funding program administration and disability benefits are of concern to both DoD and VA. Budgetary considerations are very important, but neither the taxpayer nor the service member being discharged for disability cares whether the costs of disability benefits are covered by the DoD budget or the VA budget or some combination of the two. Taxpayers and service members care that people disabled in the service of our country receive prompt and appropriate compensation, health care, and other benefits.

Short-Term Recommendations:

Recommendation 7.9

DoD should reassess the policy of allowing separation without compensation for individuals found unfit for duty who are also found to have a preexisting disability for up to 8 years of active duty.

Recommendation 7.10

VA and DoD should adopt a consistent and uniform policy for rating disabilities, using the VA Schedule for Rating Disabilities.

Recommendation 7.11

DoD should reassess the ratings of service members who were discharged as unfit but rated 0 to 30 percent disabled to determine if those ratings were equitable. (Note: Commission data only went back to 2000.)

Long-Term Recommendations:

Recommendation 7.12

VA and DoD should realign the disability evaluation process so that the services determine fitness for duty and service members who are found unfit are referred to VA for disability rating. All conditions that are identified as part of a single,

comprehensive medical examination should be rated and compensated.

VI Cost of Living Adjustments

Adjustments to disability compensation payments and other benefits are collectively known as the cost of living adjustments (COLA). The Commission examined the adequacy of the COLA process and questioned whether COLAs have effectively kept pace with inflation. The Commission found that, although benefit payments are not automatically indexed to inflation for most benefits, disability compensation and DIC payments are adjusted annually by acts of Congress to reflect the cost of living.

By contrast, payments for ancillary and special-purpose benefits are adjusted individually and periodically. Many ancillary and special-purpose benefits have not been adjusted for years and have not kept pace with the actual costs of goods and services or with the original intent of Congress. For example, the automobile allowance was originally intended to cover 80 percent of the average cost of a new vehicle. Yet because that allowance has not been adjusted to reflect real costs, the benefit covered only 39 percent of the average cost of a new light vehicle in 2007.⁹³

Table 7.8 illustrates when the level of each of the ancillary and special-purpose benefits was last updated by Congress.

⁹³ Calculation based on the amount of the automobile allowance (\$11,000) and the average cost of a new light vehicle in 2007 (\$28,500) (E-mail from John Thomas, National Automobile Dealers Association, to Jacqueline Garrick, Commission staff, September 27, 2007).

Table 7.8 Ancillary and Special Purpose Benefits Last Increased

BENEFIT	LAST INCREASED
SDVI	1951
Beneficiary Travel	1978
Home Improvement Structural Alteration	1992
VMLI	1992
Automotive & Adaptive Equipment	2001
Burial and Memorial Benefits	2001
Specially Adapted Housing (SAH)	2002
Special Housing Adaptation Grants	2003
TSGLI	2005*
Birth Defects Benefits	2005
Clothing Allowance	2006
Special Monthly Compensation	2006
Vocational Rehabilitation & Employment	2006
Aid & Attendance	2006
Housebound	2006
Dependency & Indemnity Compensation	2006

*Retroactive to 2001 for injuries incurred in OIF/OEF.

Another issue the Commission examined is the practice of keeping benefits and COLA increases uniform across the country rather than making adjustments for geographic variance in the cost of living. For example, the cost of adapting housing to accommodate severe disabilities varies according to local construction costs yet the benefit maximum is uniform across the country.

Recommendation 7.13

Congress should enact legislation that brings ancillary and special-purpose benefits to the levels originally intended, considering the cost of living, and provides for automatic annual adjustments to keep pace with the cost of living.

VII State Court Spousal Support Obligations

VII.1 Issue

Should veterans' benefits be considered by State courts in spousal support proceedings? Veterans believe that their basic disability benefits are being considered by State courts as marital property or family income earned during the marriage that is available for division in divorces. States have the primary responsibility for family issues, including determining spousal support awards. Support for spouses, and children, when the veteran does not provide it, can be

awarded by VA as an apportionment of the veteran's disability benefits. Support can also come as a garnishment of military retired pay by a court order. Congress recognizes a veteran's need for additional benefits to support their dependents and provides veterans with disability ratings between 30 and 100 percent additional benefits for a spouse and for each minor child. A veteran cannot receive additional compensation for a former spouse.

The U.S. Supreme Court decided in *Rose v. Rose* (1987) that a state court has jurisdiction to hold a disabled veteran in contempt for failing to pay child support to force compliance, even if the veteran's only means of satisfying this obligation is to utilize compensation (*Rose v. Rose*, 481 U.S. 619 [1987].) Otherwise, veterans' benefits are exempt from the claims of other creditors and are not subject to attachment by any legal or equitable process.

VII.2 Apportionment

An apportionment is the allocation of VA benefits between a veteran and his or her dependents. When determining if and how to apportion benefits, consideration is given to the amount of benefits the veteran receives, the veteran's resources as compared to the dependent's resources, and the special needs of the veteran and his or her dependents (38 C.F.R. § 3.451 [2006]). Former spouses are not entitled to apportionments, but may receive benefits as the custodian of the veteran's children.

VII.3 Garnishment

A garnishment is a legal procedure in which a person's earnings are required by court order to be withheld by the employer or source agency for the payment of a debt. Military retirees may waive some or all of their military retired pay in order to receive VA compensation (38 U.S.C. § 5304 [2006]). This waiver of military retirement pay allows for the garnishment of VA compensation up to the amount of military retired pay waived to pay child support and alimony (5 C.F.R. § 581.103[c][7] [2006]). The Uniformed Services Former Spouses' Protection Act (USFSPA) of 1982 gave State courts of military retirement benefits should not be impeded by congressional preemption of State law.⁹⁴

VII.4 Traumatic Servicemembers' Group Life Insurance

Traumatic Servicemembers' Group Life Insurance (TSGLI) provides payment to any service member who sustains a traumatic injury. The intent of the payment is to help service members and their families cope with the financial impact of

⁹⁴ Willick, *Garnishment of Benefits*.

long recuperation periods, temporary family relocation, and other unexpected expenses following a traumatic injury. If these funds are commingled with other joint funds, they become marital property.

VII.5 Findings

Veterans view their basic disability compensation benefits as payment for the effects of their disability, and not as earnings. Therefore, their disability benefits should not be divided by garnishment. Veterans have a responsibility to support their dependents and are provided additional benefits for this purpose. While spouses claim that they should share in all benefits acquired during the course of a marriage, a veteran's basic disability benefits, and the needs of the veteran, must be considered. The trend at the state level is to award alimony to former spouses without considering that once divorced, a veteran is no longer entitled to an additional allowance for that dependent.

Except for the compensation equal to the military retired pay waived to receive compensation, the Commission believes that disability benefits, provided to disabled veterans, should be exempt from contempt citations, claims of, or attachment by State courts. Former spouses are not considered dependents by VA, and veterans cannot continue to receive any additional disability benefit, once divorced. Therefore, State courts should not consider a veteran's disability benefits in spousal support determinations.

Recommendation 7.14

VA disability benefits (including Traumatic Servicemembers' Group Life Insurance), except VA compensation benefits received in lieu of military retired pay, should not be considered in state court spousal support proceedings.

VIII Lump Sum Payments

VIII.1 Issue

For years a debate has simmered over the appropriateness of lump sum payments to compensate veterans for service-connected disabilities. A number of studies, including the Bradley Report, have recommended that VA investigate the viability of using lump sums, either in place of or in conjunction with monthly compensation, to compensate for decreases in quality of life. In the current system, monthly disability payments are intended to compensate for impairment of earnings capacity, though some argue that there is also an implied quality-of-life aspect to these monthly payments. Proponents of lump sum payments argue

that quality-of-life issues are better addressed through a single lump sum payment, rather than through lifetime monthly payments. In particular, these proponents argue that lump sums would be more appropriate for veterans with less severe disabilities. After deliberating the issue, however, the Commission concluded that lump sum payments are impractical and potentially detrimental to veterans, and therefore should not be made.

A number of government reports and commissions have recommended that lump sum payments be investigated as a means to better compensate veterans for their disabilities. In its 1956 report to the President, the Bradley Commission investigated the possibility of including lump sum payments as a means of compensation for less severe service-connected disabilities. The Bradley Commission found that disabled veterans rated 10 percent or 20 percent did not have a "loss of physical vitality or impairment of health."⁹⁵ Believing that monthly payments should be paid to veterans who have a loss of earnings capacity, the Bradley Commission decided that "the soundest course of action [for VA] would appear to be to find some method of discharging the obligation to such cases once and for all, and to remove them from the monthly payment files."⁹⁶

Several decades later, in its 1996 report to Congress, the Veterans' Claims Adjudication Commission (VCAC) investigated the positive and negative aspects of lump sum payments. Focusing on veterans who are rated 10 percent disabled, the VCAC saw a lump sum payment as a means of assisting veterans with their transition to civilian life. The VCAC argued that, whereas seriously disabled veterans "can be expected to require ongoing, long-term support, those who are minimally disabled may be better served by concentrating the support at the point of transition to civilian life."⁹⁷ This conclusion was largely based on VCAC's examination of the DoD and DOL compensation schemes, which both use lump sum payments in certain circumstances to compensate for disabilities that do not "seriously impair civilian earnings capacity."⁹⁸

More recently, in a 2005 report titled *Veterans Have Mixed Views on a Lump Sum Disability Payment Option*, GAO surveyed a group of veterans about their opinions of a "broadly defined hypothetical program that would give veterans the option of taking a one-time lump sum payment."⁹⁹ GAO's survey and focus-group questions were based on a system that compared a monthly payment with a lump sum payment in which both payments would be tax free. According to GAO's survey, 49 percent of veterans questioned said "they would definitely or probably support a lump sum option for newly compensated veterans, [and] 43

⁹⁵ President's Commission, *Findings and Recommendations*, 176.

⁹⁶ *Ibid.*

⁹⁷ Veterans' Claims Adjudication Commission (VCAC), *Report to Congress*, 273.

⁹⁸ *Ibid.*, 279, 280.

⁹⁹ GAO, *Veterans Have Mixed Views*, 4.

percent said they would definitely or probably not support it.”¹⁰⁰ GAO’s study also showed that younger veterans would be more open to receiving a lump sum payment than would older veterans.¹⁰¹ That same year, the VA Office of Inspector General (OIG) released a report entitled *Review of State Variances in VA Disability Compensation Payments* that compared the disparity in veterans’ benefits payments from state to state. A lump sum payment plan was recommended to improve the compensation program. When considering lump sum payments, the OIG report indicated “that [a lump sum payment] continues to be a viable option for veterans with minor disabilities.”¹⁰² The OIG report suggested that VA pay a lump sum to veterans who are rated 20 percent or less, stating that this “would result in reducing 46.9 percent or 1.17 million active case files,” or approximately \$1.96 billion in ongoing monthly compensation.¹⁰³

In addition to recommending that the lump sum issue be more comprehensively examined, several of the above reports identified potential advantages and disadvantages to such a system. Advantages included the fact that a veteran with a less severe disability would be given capital that would assist him or her with transition into civilian life, and that a lump sum payment plan would reduce repeat claims, simplifying the process for veterans and reducing administrative costs for VA. The reports also identified a number of significant disadvantages to lump sum payments. Certain veterans might have to reapply for additional compensation if their disability worsened over time, for example, and poor spending habits might lead veterans to spend the money in ways that are not in their best interests for long-term investments. GAO noted a major problem for any system using lump sum payments: if a veteran’s condition worsened, VA would not be able to reevaluate the disability.¹⁰⁴

To finally develop a comprehensive analysis of this ongoing debate, the Commission contracted with CNAC to conduct a study of lump sum payments as a means of compensation for disabilities as an alternative to monthly payments. In the course of its investigation, CNAC identified three primary benefits that lump sum payments could provide to veterans: they could reduce interactions with VA administrators; they could prove more useful to a veteran than continued monthly payments; and, if the lump sum was optional, the veteran would be given greater control over their means of compensation.¹⁰⁵ In addition to these benefits to the veterans, CNAC also identified benefits for VA, particularly that VA could save money if the lump sum payment was “less than equivalent to the present value of the veteran’s lifetime monthly payment.”¹⁰⁶ VA could also reduce

¹⁰⁰ Ibid., 7, 8.

¹⁰¹ Ibid., 10.

¹⁰² VA Office of Inspector General, *Review of State Variances*, 39.

¹⁰³ Ibid.

¹⁰⁴ GAO, *Veterans Have Mixed Views*, 10.

¹⁰⁵ CNAC, *Lump Sum Alternatives*, 3.

¹⁰⁶ Ibid., 2.

the number of claims processed if it restricted a veteran's ability to have his or her disability reevaluated, which could reduce administrative costs.

In contrast to these hypothetical advantages of a lump sum payment system, CNAC identified a number of disadvantages. First, there is the concern "that the lump sum should be 'fair' in comparison with lifetime monthly compensation payments."¹⁰⁷ It is difficult to determine what dollar amount the veteran population would perceive as just compensation for disabilities incurred during military service, particularly given the arguments that favor lump sum payments as a means of saving money by decreasing lifetime benefits for some veterans. To achieve both a savings for VA and a fair payment for veterans, "it is important to be able to reliably estimate the personal discount rates¹⁰⁸ of disabled veterans. Unfortunately, there is no relevant literature specifically on that population that we can cite."¹⁰⁹ In a lump sum program, CNAC found that "savings would be affected by which disabilities and ratings would be eligible for a lump sum and what personal discount factor would be used when calculating the lump sums." In its estimates for selected disabilities, CNAC found "savings in lifetime compensation payments from a lump sum program ranging from about 10 to 21 percent when calculated just over the disabilities within those diagnostic codes."¹¹⁰ It is important to note that CNAC focused on specific disabilities rather than overall disability ratings. When calculating the long-term budgetary effects of a lump sum payment system, CNAC reported that the savings that could result from such a system would depend on many factors. CNAC recommended that if lump sum payments were seriously considered, further study of the veteran population should be conducted to determine levels of lump sum payments.

CNAC estimated the financial impact of making lump sum payments in 2006 to veterans with ratings of 10 percent or 20 percent for those diagnoses for which the ratings increased less than 2 percent between 2000 and 2005 (Table 7.9). The estimate considered two scenarios, one in which lump sum payments would be made only for veterans with new disabilities and another for all disabilities CNAC deemed suitable for lump sums. Considering the total budget for disability compensation payments of \$21.2 billion in 2006, lump sum payments would increase the budget by 31 percent if paid to all veterans meeting the above criteria. If paid only for new disabilities, the budget increase in 2006 would be 2.6 percent. In either case, the break-even point would be lengthy, 17 years for all disabilities and 25 years for new disabilities.

¹⁰⁷ Ibid.

¹⁰⁸ In conducting this analysis CNAC looked at personal discount rates, which are based on an individual's tendency to prefer to receive a particular amount of money in the present rather than receiving an equivalent amount in the future.

¹⁰⁹ CNAC, *Lump Sum Alternatives*, 27, 28.

¹¹⁰ Ibid., 75.

Table 7.9 Estimates of the Effect of a Lump Sum Program on Disability Compensation Payments

EFFECT OF LUMP SUM PROGRAM ON TOTAL COMPENSATION PAYMENTS (B)	ALTERNATIVE PROGRAM RULES: WHICH DISABILITIES WOULD BE ELIGIBLE FOR A LUMP SUM (A)	
	New disabilities only	All disabilities
Single-year effect		
1 st year (c) (d)	\$545 million increase	\$6,660 million increase
5 th year	\$327 million increase	\$306 million decrease
10 th year	\$88 million increase	\$462 million decrease
Cumulative effect		
5 th year	\$2.2 billion increase	\$5.6 billion increase
10 th year	\$3.1 billion increase	\$3.6 billion increase
Break-even point (e)	25 years	17 years

SOURCE: CNAC. Lump Sum Alternatives to Current Veterans' Disability Compensation, 8–9.

Another potential problem with lump sum payments is “the treatment of cases where the disability worsens.”¹¹¹ Although it may be easy to make lump sum payments for one disability rated at a specific level, difficulties will arise in cases where the disability worsens or the veteran has multiple disabilities that must be combined to calculate a monthly rate of compensation. CNAC analyzed changes in disability ratings by using “the Compensation and Pension Master Record (CPMR) data files for December 2000 and December 2005 from the Veterans Benefits Administration (VBA).”¹¹² It found that each diagnosis should be considered individually with respect to eligibility for a lump sum offer because each has different probabilities of worsening. In particular, disabilities such as PTSD and other mental disorders are prone to significant variations over the course of a veteran’s lifetime, posing significant problems for a potential lump sum payment plan. If a veteran’s disability worsens over time, but a lump sum has already been paid, then that veteran’s compensation would have to be reevaluated, negating the proposed benefits of a single-evaluation lump sum system and making calculations of benefit amounts exceedingly complicated. If that veteran’s compensation was not reevaluated, then he or she would not receive the fair amount of disability compensation to which he or she was due.

¹¹¹ CNAC, *Lump Sum Alternatives*, 2.

¹¹² *Ibid.*, 6.

The lump sum programs used by the United Kingdom, Australia, and Canada were also reviewed by the Commission staff but information was not available on estimated savings or if the number of claims were reduced.

VIII.2 Findings

The concept of lump sum payments for certain less severely disabled veterans has been discussed repeatedly over the years. On the surface, the concept appears to have some merit. However, from its deliberations, the Commission concluded that this concept should not be considered. Lump sum payments would require a complete change in the philosophical basis for the disability compensation program. A great amount of additional analysis would have to be conducted to determine the appropriate program design features of lump sum payments that would ensure fairness, effectiveness, and efficiency. In addition, a major policy decision would have to be made as to whether reevaluation would be possible if disabilities worsened over time. Although it may be theoretically possible to design a set of criteria that would enable reevaluation of those veterans whose conditions became catastrophically or seriously disabling, applying such criteria would be operationally difficult. In addition, the criteria would likely have to be revised over time to include less severe conditions due to court reviews and political pressure. Such revisions would defeat the goals of lump sum payments.

The complexity of lump sum payments would likely be excessive and difficult for veterans to understand and accept. The complexity would also be difficult and costly to administer. Additionally, there is serious concern about a veteran's ability to wisely manage lump sum payments. Finally, lump sum payments would have significant short-term impact on the budget of the United States and the break-even point when the up-front costs would be offset by future savings would be many years in the future, effectively negating the argument for lump sum payments as a means to decrease the VA budget. In light of all of these significant problems, the Commission concluded that lump sums should not be considered as an appropriate form of VA disability compensation.

Recommendation 7.15

Lump sum payments should not be considered to compensate veterans for their disabilities.

IX Social Security Disability Insurance

The Commission became concerned with the eligibility of severely injured service members for Social Security Disability Insurance (SSDI) awarded by the Social

Security Administration. The purpose of the SSDI program is to partially replace earnings of individuals who are unable to work because of a disability. The program defines disability as the inability to engage in “substantial gainful activity” (SGA) due to long-term physical or mental impairment, and SGA is defined as earnings above a certain amount. Both eligibility for SSDI and SSDI compensation levels depend on an individual’s earnings history.¹¹³

In reviewing the appropriateness of the level of benefits provided to veterans and service members, the Commission found that only 15.9 percent of service-connected veterans receive SSDI. Among veterans granted IU, only 61 percent receive SSDI, and among veterans rated 100 percent, only 54 percent receive SSDI. Only 61 percent of veterans rated 100 percent who receive special monthly compensation in the SLMN or O categories also receive SSDI, while 81 percent of veterans rated 100 percent who receive special monthly compensation in the R1 or R2 categories also receive SSDI. Given the very low earnings of those rated 100 percent and the exceptionally low earnings of the IU group, many more service-connected veterans should be receiving SSDI.

The current rates of participation in the SSDI program by service-disabled veterans strongly indicate that many of these individuals either do not know to apply for SSDI or are being denied eligibility. VA and the Social Security Administration should increase outreach to these veterans to educate them about SSDI and should improve coordination to achieve higher rates of mutual acceptance of decisions to grant SSDI to service-disabled veterans.

The Commission also felt strongly that the SSDI program should include the severely injured even if an individual does not meet the minimum credits required for SSDI eligibility. For example, a disabled person under age 24 must have six credits earned in the 3-year period ending when disability starts. Many of the service members begin their work experience in the military and may not have had the opportunity to have earned sufficient quarters to qualify for SSDI benefits.

In Chapter 10, the Commission discusses SSDI as it relates to the transition of severely injured service members and makes recommendations.

¹¹³ CNAC, *Final Report*, 133, 134.

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8

Survivors and Dependents

The Department of Defense (DoD) has authorization under title 10 of the U.S. Code (U.S.C.) to provide a wide spectrum of services to family members, which not only include spouses and children, but also parents, siblings, extended family, and significant others. This broad definition of family is applied when DoD gives support to next of kin or survivors. DoD can provide significant financial assistance, travel assistance, and housing near military treatment facilities for these families.

By contrast, when a service member separates from active duty, becomes a veteran, and applies for benefits and services from the Department of Veterans' Affairs (VA), the types of benefits and services VA can provide family members are very few. Under 38 U.S.C., VA has no statutory authority to treat or assist veterans' family members, other than in some very limited capacities. There is no VA office that mirrors DoD's Military Community and Family Policy Office. There are no special programs or projects designed for the spouses, children, parents, or siblings of severely injured veterans. VA cannot give family members of veterans the same kinds of travel and per diem benefits as those offered by DoD when an injured service member is recuperating while on active duty. Substantial family support, which DoD often identifies as a main component of successful transition, is a benefit that VA can not presently provide. (See recommendation 10-12).

I Definitions of Survivors and Dependents

A surviving spouse is legally defined by VA as "a person of the opposite sex who was the spouse of the veteran at the time of the veteran's death...and who has not remarried...since the death of the veteran, or...held himself or herself out openly to the public to be the spouse of such other person" (38 U.S.C. § 101 [3] [2006]).

An individual may be considered to be a spouse if the couple's marriage was in accordance with the law of the place where the parties resided at the time of the marriage (38 U.S.C. § 103 [c] [2006]).

A child is defined as a person who is unmarried and

- is under age 18, or
- became permanently incapable of self-support before age 18, or
- between ages 18 and 23 is pursuing education or training at an approved educational institution, or
- was legally adopted by the veteran, or
- is a stepchild of the veteran, or
- is an illegitimate child of the veteran (38 U.S.C. § 101[4][A][i]–[iii], [B] [2006]).

Dependents can be spouses, minor children, or parents. A parent is considered a dependent of the veteran before or after the veteran's death if their monthly income is less than the maximum levels that the VA Secretary has prescribed by regulation, giving due regard to the marital status of the parents and any additional family members who are (their dependents) (38 U.S.C. § 102[a][b] [2006]).

II Appropriateness of the Benefits

The Commission assessed whether the benefits available for survivors are appropriate. The benefits and services currently available to survivors has its basis in the veteran's service and resulting disability and the survivor's relationship to the veteran. Again, to the maximum extent possible, the impact of the loss of the veteran and his or her income on the survivors is mitigated, and benefits and services (e.g., dependency and indemnity compensation, death pension, home loan, and education) are made available based on the circumstances of the veteran's death.

II.1 Survivors

Both DoD and VA offer benefit programs to the survivors of deceased veterans whose death was due to service. The DoD survivor benefit program, which is open to all survivors of retirees and of service members who die on active duty is called the Survivor Benefit Plan (SBP). It is similar to an annuity option under a life insurance plan, purchased with premiums paid by a retiree but free to survivors of service members who die on active duty.

By contrast, VA's Dependency and Indemnity Compensation (DIC) program is only for survivors of veterans whose deaths occur on active duty, are service

connected, or follow from a period of permanent and total service-connected disability. DIC also differs from SBP in that it is a tax-free, flat-rate, monthly payment.

II.1.A DoD's Survivor Benefit Plan

The DoD's Survivor Benefit Plan was established in 1972 by Public Law 92-425 "to ensure that the surviving dependents of military personnel who die...will continue to have a reasonable level of income."¹ SBP is available to all military retirees as part of their retirement package. As of September 11, 2001, all surviving spouses, surviving children, or both of individuals who died while on active duty became entitled to SBP without regard to the number of years served. The spouse, children, or both of active service members are covered by SBP (National Defense Authorization Act for Fiscal Year 2002, Pub. L. No. 107-107 § 642, 115 Stat. 1012 [2001]). Military retirees receive retirement pay from DoD, but this retirement pay ceases once the retiree dies. A military retiree may choose to pay a certain amount of his retirement pay into the SBP program, which will then provide a monthly annuity to his or her survivors. Immediately prior to retirement, the service member elects SBP. After the retiree's death, the annuity paid to her or his beneficiaries will equal 55 percent of the base amount.² Thus, "full" SBP coverage—meaning the base amount is equal to the veteran's complete monthly retirement payment—will give the veteran's survivors 55 percent of his or her retirement pay, an amount chosen because similar federal government programs determined 55 percent as a "reasonable level of income." In the case of an active-duty death, the SBP benefit amount is based on the amount of retired pay as if the member, if eligible, retired on the date of death or, if not retirement eligible, as if the member were 100 percent disabled on the date of death.

II.1.B VA's Dependency and Indemnity Compensation

The Dependency and Indemnity Compensation (DIC) program was established in 1957 as "indemnification for the service-connected death and partial compensation for the resulting economic loss to survivors."³ Congress intended for DIC to serve as recognition of the sacrifices made by service members and veterans whose deaths are service-related and to replace a significant portion of income lost after a veteran's death, while providing a minimum level of income and an acceptable standard of living for eligible surviving spouses and the dependents of veterans.

¹ Department of Defense, *Military Compensation Background*, 906–907.

² Department of Defense, *Military Compensation*, 1.

³ VA Office of Policy, *Program Evaluation of Benefits*, 11.

Originally, a veteran's death was required to be the result of a service-connected condition for survivors to qualify for DIC. Since 1978, however, the benefit has been extended to survivors of those veterans with a service-connected disability rated at 100 percent for a period of 10 years, regardless of whether the cause of death was service connected (Pub. L. No. 84-881, 70 Stat 8870 [1956]). When a service-connected veteran dies, DIC provides a monthly payment of \$1,067, as of 2007. There are several other benefits such as those for a dependent child and a housebound surviving spouse.⁴ As of March 2007, there were an estimated 314,719 surviving spouses receiving DIC benefits, at an annual cost of \$4.36 billion.⁵ Over 63,000 surviving spouses had their SBP partially or totally offset by their DIC.

II.2 Dependents' and Other Survivors' Benefits

II.2.A Compensation

Veterans with service-connected disabilities of 30 percent or greater receive additional compensation for dependents. Veterans with disabilities rated 30 percent to 90 percent receive for each dependent that fraction of the allowance for a dependent of a veteran rated 100 percent that corresponds to their percentage ratings. The additional compensation for a child who became permanently incapable of self-support will continue for the life of that child. Lastly, the additional compensation for the child while in school is at a higher rate than the normal additional compensation for a child to help offset the cost of that education or training.

II.2.B Health Care under CHAMPVA

To provide medical care for dependents and survivors of totally disabled veterans and survivors of veterans who died of service-connected causes, Congress created the Civilian Health and Medical Program of the Department of Veterans Affairs, CHAMPVA, by Public Law 93-82, enacted in 1973. Specifically, the program reimburses the costs of the following types of medical care: inpatient, outpatient, pharmacy, mental health, prescription medication, skilled nursing care, and durable medical equipment.

The eligible dependents include

- spouses and children of permanently and totally disabled veterans, or
- surviving spouses or children of a veteran who died from a VA-rated service-connected disability, or who at the time of death, was rated permanently and totally disabled, or

⁴ Carroll, *Dependency and Indemnity Compensation*.

⁵ Wells, E-mail, April 18, 2007.

- surviving spouses and children of military members who die on active duty and are not otherwise eligible for the Defense Department's Tricare program.

As of 2005, the most current data, there are approximately 190,000 permanent and total (P&T) veterans who have 263,700 beneficiaries enrolled in CHAMPVA, of which approximately 40,000 were children and another 213,941 were adults between the ages of 26 and 64, although only 103,555 of these enrollees were actual users. With Medicare eligibility, it becomes the primary payer and CHAMPVA is secondary. Because VA identifies and categorizes beneficiaries by age distribution and gender only, the Commission could not distinguish between those who are eligible as spouses and those who are eligible as children for purposes of estimating the total numbers in each.

In general, 40 percent of CHAMPVA enrollees use it as a secondary insurance and have another plan as a primary. Approximately 25,000 beneficiaries became entitled in FY 2006, and 18,000 lost their eligibility.

There are also parents, grandparents, siblings, and significant others who are caregivers to veterans who do not have legal status as dependents of the veteran for whom they provide care. Therefore, they are not eligible for CHAMPVA. However, many of these individuals give up jobs, along with their health insurance, to care for a severely disabled veteran. Extending CHAMPVA eligibility to these individuals while they are providing care would provide the veteran with a healthier caregiver and reduce the burden on the person who has taken on this role. Consideration should also be given to providing the caregiver a benefit like a "caregiver allowance" as an incentive to continue providing care to the severely disabled veteran.

Recommendation 8.1

Congress should extend eligibility for the Civilian Health and Medical Program of the Department of Veterans Affairs to caregivers and create a "caregiver allowance" for caregivers of severely disabled veterans.

II.2.C Survivors' and Dependents' Educational Assistance Program

Congress intended the Survivors' and Dependents' Educational Assistance program, chapter 35, for the spouse of a veteran to support the veterans' family at a standard of living consistent with the level that a veteran could have expected to provide for his or her family had the veteran not become disabled or

died. The benefit is also intended to provide educational opportunities to the surviving spouses and children of service-connected disabled veterans. A beneficiary is eligible for chapter 35 benefits if the veteran

- died of a service-connected disability, or
- has a total disability permanent in nature resulting from a service-connected disability (includes 100 percent schedular evaluations or those being paid at the 100 percent level due to receipt of Individual Unemployability (IU) benefits with no future examination scheduled), or
- is missing in action, or
- captured in line of duty by hostile force, or
- forcibly detained and/or interned in line of duty by a foreign government or power.⁶

Chapter 35 benefits are provided starting at the age of 18 or on the successful completion of the person's secondary schooling, whichever occurs first, and ending when the person completes their education or on the person's 26 birthday. Entitlement to chapter 35 is for 45 months.

As of 2008, 86,400 survivors will receive chapter 35 benefits.⁷ VA projects chapter 35 benefits to increase to \$478,342,000 by FY 2008.⁸

II.2.D Bereavement Counseling

Bereavement counseling is available to all family members including spouses, children, parents, and siblings of service members who have died while on active duty. Family members of service member activated from the National Guard and reserves are also eligible. In 2006, over 800 families of service members killed in Iraq or Afghanistan received counseling.

Presently, there is little else in the way of grief counseling for families provided by VA. This resource is vital in supporting service members' families. They need to be aware of available benefits, especially for National Guard and reserve families and families in rural areas.

II.2.E Burial Benefits

Burial in a VA National Cemetery is available for eligible veterans, spouses, and dependents. They are only eligible for a headstone or a marker if buried in a national or state veterans' cemetery. The veteran does not have to predecease

⁶ Cornell University, "Subsection 3501."

⁷ VA Summary Volume IV. 1-17

⁸ Ibid., 3A-14

his or her dependents for them to be eligible. Under certain circumstances, deceased veterans may also be entitled to a burial flag, a burial allowance, and a plot allowance. Surviving spouses of veterans who die after January 1, 2000, do not lose their eligibility for burial if they remarry.

II.2.F Benefits for Birth Defects

Vietnam veterans' and some Korean veterans' children who suffer from spina bifida or certain other birth defects may be eligible for a monthly monetary benefit, health care for their disability, and vocational training.

II.2.G Home Loan Guaranty

A VA home loan guaranty may be available to a surviving spouse of a veteran or service member who died as a result of a service-connected disability; this includes the spouse of a service member listed as missing in action or a prisoner of war (POW) for more than 90 days. The surviving spouse of a service member who was missing in action or a prisoner of war is limited to one loan.

II.2.H Veterans' Preference

A dependent of a deceased veteran is eligible for a 10-point veterans' preference for federal employment if

- she or he is the unmarried spouse of certain deceased veterans, or
- the spouse of a veteran unable to work because of a service-connected disability, or
- the mother of a veteran who died in service or who is permanently and totally disabled, where the father is also permanently and totally disabled.

II.2.I Aid and Attendance

A veteran who is rated 30 percent or more disabled is entitled to receive an additional payment for a spouse. This spouse may need aid and attendance by another caregiver. Should the spouse need such aid and attendance, the veteran will be awarded an additional allowance.

III Appropriateness of the Level of Benefits

The survivor and dependents' benefits previously described for their appropriateness were also reviewed by the Commission for their level of compensation (as applicable.)

III.1 Survivor Concurrent Receipt

III.1.A Issue

When the survivors of a retiree are eligible for both SBP and DIC, the survivors' SBP payments are offset, or reduced, by the amount of their DIC payment. The level of SBP benefit is reduced by one dollar for every dollar of DIC benefit the survivor receives, regardless of the amount the retiree paid into the SBP system. In addition, while the offset decreases the SBP annuity, which is guaranteed to the survivor by the premium paid by the retiree, it does not decrease the overall level of survivor benefits below the guaranteed 55 percent. For survivors of retirees below the rank of E-6, the offset effectively negates most, if not all, of their SBP benefit. If the survivor's SBP is offset by their DIC, the amount the retiree paid into the SBP program relative to the amount of DIC will be refunded to his survivors without interest. Should a retiree's beneficiaries die before the retiree does, the premiums that he or she paid into SBP will revert to the U.S. Treasury.

The most common argument against the offset, again mirroring the debate over veteran's concurrent receipt, asserts that the two programs have distinctly different purposes that do not overlap, and that it is therefore unfair to offset them. It is argued that SBP is "retiree-purchased insurance," while DIC is "a special indemnity payable when military service causes the service member's premature death."⁹ Many argue that the differences in purpose between these two programs are even more pronounced than those between military retirement and VA disability compensation. SBP is fundamentally an insurance program, because the military retiree must pay a premium in order to qualify. Because the retiree has already paid into this program, many argue that it is unfair to offset the benefits guaranteed by those premiums for any reason.

Those in favor of the offset argue that SBP and DIC both compensate a veteran's survivor for a single event, namely the veteran's death. Other arguments against survivor concurrent receipt focus on the costs to the Federal Government of removing the offset. DoD has estimated that eliminating the SBP/DIC offset would cost DoD \$6.8 billion during the first 10 years.¹⁰ As in the debate over veteran's concurrent receipt, this argument also points to a study that revealed that eliminating the offset between DoD retirement and VA disability benefit would result in little, if any, measurable increase in recruitment or retention.¹¹

⁹ Military Officers Association, "Widows Hit Hard."

¹⁰ Office of Management and Budget. *Administration Policy on S.2766*.

¹¹ Dye, *Prohibition on Concurrent Receipt*, 20.

III.1.B Findings

The arguments surrounding survivors' concurrent receipt are in many ways similar to those surrounding veterans' concurrent receipt. Those opposed to eliminating SBP offset say it would be too costly to the military. In addition, they claim that there would be no discernable increase in recruitment or retention rates as a result of concurrent receipt. Those in favor of concurrent receipt for survivors, however, argue that the two programs have distinctly different purposes, and it is therefore unfair to offset one by the other. Moreover, SBP premiums are paid by the retiree, and are therefore akin to an insurance program. The retiree pays a certain payment in order to guarantee a certain annuity for his survivors, and many argue that it is unfair to subtract from this guaranteed annuity. Eliminating the SBP/DIC offset would acknowledge the difference in the purpose of these two benefits and allow survivors of those whose death was as a result of military service to receive additional compensation.

To date, no laws have been passed to eliminate the SBP/DIC offset. The Commission finds that the purposes of the DIC and SBP programs are distinctly different: DIC compensates for deaths related to service while SBP provides a continuing retirement payment for the survivors of all retirees regardless of the cause of death. The Commission is particularly concerned with the situation of the enlisted survivors. The Commission also finds that refunding premiums without interest is not justified. The Commission concluded that the offset of SBP by DIC payments is not appropriate and should be discontinued.

Recommendation 8.2

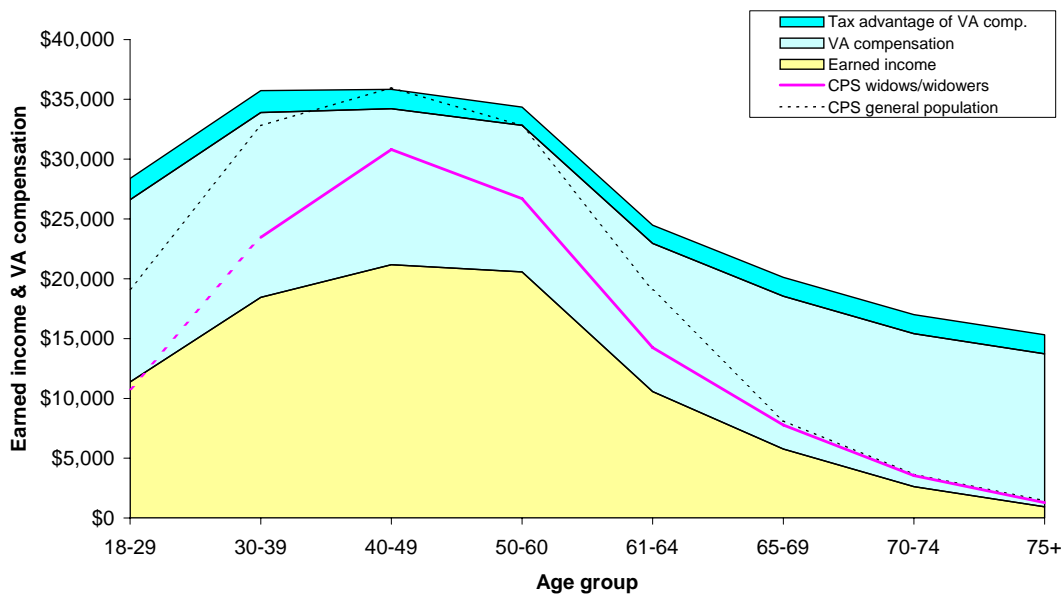
Congress should eliminate the Survivor Benefit Plan/Dependency and Indemnity Compensation offset for survivors of retirees and in-service deaths.

III.2 Earnings

To better assess the adequacy of benefits for survivors of deceased veterans, the Commission contracted with the CNA Corporation (CNAC) to include surviving spouses in its economic analysis of veteran's benefits. Using techniques similar to those used in analyzing benefits for veterans, CNAC concluded that a veteran's disability does have a negative financial effect on surviving spouses, but that current benefits paid to surviving spouses are comparable to or higher than the earnings of widowers and widows in the general population.

At all ages, surviving spouses of veterans have lower employment rates than widows in the general population. In addition, they have lower earned income than widows in the general population, as illustrated in Figure 8.1. In this figure, the thin pink line represents surviving spouses in the general population, while the dotted blue line represents the general population itself. The blue line at the edge of the yellow area represents veterans' surviving spouses, and at every age, these spouses have a significantly lower average earned income than both the general population and other surviving spouses. The data depicted in the chart shows that DIC and surviving spouses' earnings equates to the current population survey (CPS) of widows and widowers' income.

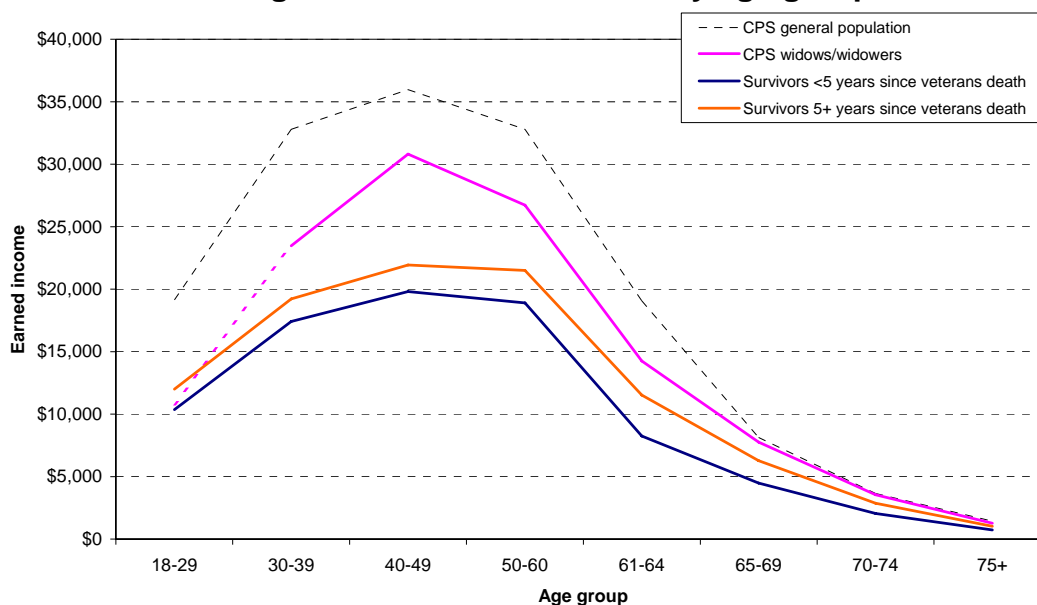
Figure 8.1 Earned Income and VA Compensation by Age Group.



SOURCE: CNAC, *Final Report*, Page 103.

The economic impact of a veteran's death is most significant for younger widows (Figure 8.1). CNAC also found that impairment of employment and earnings are most severe within 5 years of the veteran's death, as shown in Figure 8.2.¹² This indicates that the most significant economic consequences of a veteran's death are incurred during the spouse's transition, although these consequences do continue throughout the spouse's lifetime.

¹² CNAC, *Final Report*, 104–106.

Figure 8.2 Earned income by age group

SOURCE: CNAC, *Final Report*. Page 105.

In examining the specific effect of the SBP/DIC offset, CNAC found that surviving spouses younger than 40 whose benefits were offset had lower employment rates and lower average earnings than spouses whose benefits were not offset. After the age of 40, the offset has no discernable effect on either employment or earnings.¹³ CNAC also found that DIC payments were adequate for every group of survivors studied.¹⁴ In addition, survivors seemed to be generally satisfied with their compensation. Eighty-nine percent of survivors were satisfied with their DIC payments. Seventy-one percent of survivors were satisfied with their SBP benefit, but of those who were not satisfied, most identified the offset as the source of their dissatisfaction.¹⁵

CNAC concluded that a veteran's death does have a significant and measurable impact on his or her surviving spouse's economic situation, as evidenced by decreased employment rates and loss in average earnings. These negative effects are most severe for younger spouses, and are also more severe within 5 years after the veteran's death. However, current payments adequately compensate most survivors for these financial losses. Finally, most survivors are satisfied with their current level of compensation, although the SBP offset is the source of most dissatisfaction.

¹³ Ibid., 107

¹⁴ Ibid., 109.

¹⁵ Ibid., 119.

III.3 Quality of Life

CNAC also analyzed the effects that a veteran's disability and death has on his or her surviving spouse's quality of life. Using techniques similar to those used when surveying veterans, CNAC surveyed surviving spouses to determine how their lives were affected by the veteran's disability and death. CNAC then used the earnings analysis outlined above to determine whether the current level of benefits paid to survivors includes an implicit payment for quality of life.

First, CNAC sought to determine how the veteran's disability affected the spouse's life before the veteran's death. Of the 56.6 percent of disabled veterans who required a significant amount of care, 78.6 percent were cared for by their spouses.¹⁶ Of spouses who provided a significant amount of care, 57 percent reported negative health effects, and 83 percent reported a negative impact on their social lives. The degree of these negative effects was related to the amount of care provided.¹⁷ In addition, regardless of whether the spouse provided the care or not, 86 percent of spouses of veterans requiring significant care reported that they worried more than they otherwise would have, a statistic used as a rough measure of how the spouse's emotional health was affected by the veteran's disability.¹⁸

Having established how the spouse is affected by a veteran's disability prior to the veterans' death, CNAC then examined surviving spouses of deceased veterans. It should be noted that CNAC excluded male survivors from this analysis because they represent such a small portion of the overall survivor population. Table 8.1 provides the results of the first part of this analysis, which examined to what extent the veteran's death affects the spouse's mental and physical health.

¹⁶ A "significant" amount of care was defined as "[at least] 4 or more hours per day at least 5 days per week for at least 2 years."

¹⁷ CNAC, *Final Report*, 110.

¹⁸ *Ibid.*, 111.

Table 8.1 Physical and Mental Health Status of Women: Comparison with Women in General Population

HEALTH MEASURE AND AGE GROUP	MEANS		DIFFERENCE IS STATISTICALLY SIGNIFICANT
	Survivors	U.S. Population	
Physical Summary Score			
Ages 18-24	n.r	52.97	
Ages 25-34	54.21	52.71	
Ages 35-44	45.58	51.26	*
Ages 45-54	46.80	48.20	
Ages 55-64	40.33	46.28	*
Ages 65-75	37.05	43.60	*
Ages 75 and older	33.32	39.53	*
Mental Summary Score			
Ages 18-24	n.r	44.33	
Ages 25-34	45.49	47.22	
Ages 35-44	41.68	47.59	*
Ages 45-54	45.16	49.64	*
Ages 55-64	47.76	50.14	*
Ages 65-75	49.91	51.05	
Ages 75 and older	49.71	49.09	

Note: "n.r." indicates that results are not reportable because the sample did not contain enough respondents.

SOURCE: CNAC, *Final Report*, Page 115.

This table clearly shows that survivors tend to have worse health than the general population. CNAC was reluctant to attribute this difference solely to the veteran's death, though. Furthermore, despite tending to be in worse health than the general population, 74 percent of survivors surveyed by CNAC reported having "a lot" to "a fair amount" of overall satisfaction with their lives. Only 9 percent of those surveyed reported having little to no satisfaction.¹⁹

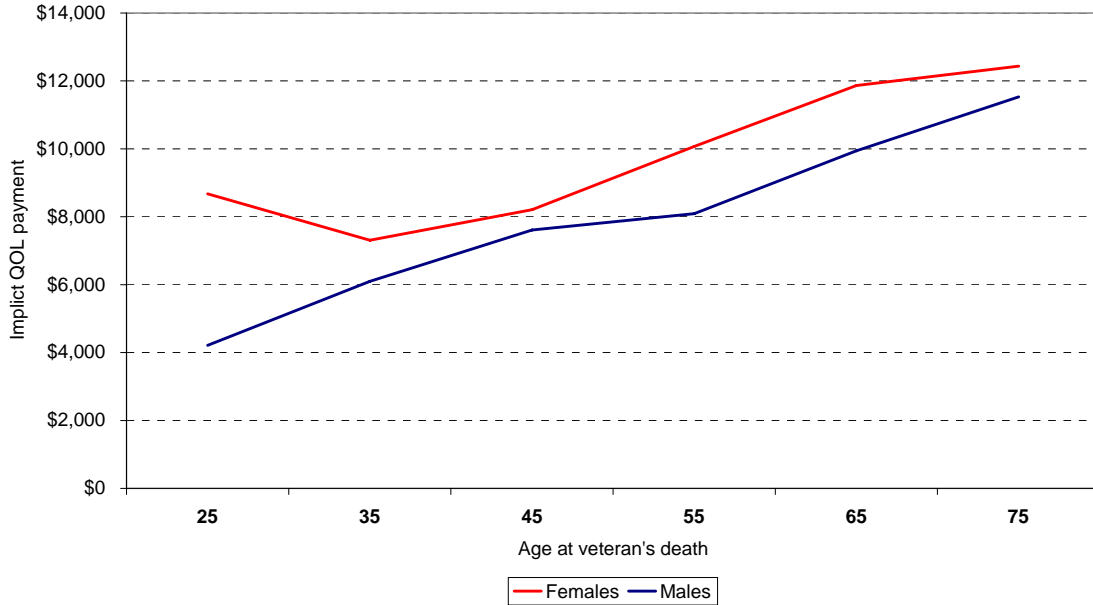
After determining what noneconomic effects a veteran's death has on his spouse, CNAC used its economic analysis of survivors to determine if there is an implicit quality-of-life payment built into the current level of the DIC benefit paid to survivors. Figure 8.3, below, clearly shows that there is a positive implicit quality-of-life payment for all survivors, and that the amount of this payment increases based on age.

Table 8.2 further quantifies this implicit quality-of-life payment. It consistently increases with age, which roughly corresponds to the decrease in overall health

¹⁹ Ibid., 116–117.

as the survivor ages. This correspondence is not perfect, though, as the table shows.

Figure 8.3 Implicit Quality-of-Life Payments by Gender and Age at Veteran's Death



SOURCE: CNAC, *Final Report*, Page 119.

Table 8.2 Summary of Earnings and Quality-of-Life Analyses

	Survivor's Age At Time of Veteran's Death					
	25	35	45	55	65	75
Annual DIC	\$12,729	\$12,729	\$12,729	\$12,729	\$12,729	\$12,729
Annual Earned Income Loss	\$4,064	\$5,402	\$4,770	\$2,854	\$945	\$294
Implicit QOL Payment	\$8,665	\$7,327	\$7,959	\$9,875	\$11,784	\$12,435
Overall Health Percentile	49%	21%	34%	28%	29%	35%

SOURCE: CNAC, *Final Report*, Page 129.

CNAC concluded that current survivor compensation levels “do not seem to be problematic.” A veteran’s disability and death clearly affect his spouse, and survivors reported increased levels of worrying, while frequently suffering from negative impacts on their education, social activities, and health. However, as the earnings analysis demonstrated, survivors are generally as satisfied with their financial situation as the general population, and 90 percent of survivors are satisfied with the current level of DIC payments. Thus, the current DIC level does provide an implicit quality-of-life payment, which, given the factors outlined above, appears to be satisfactory to most survivors.²⁰

III.4 Cost of Living Allowance (COLA) Adjustment

During the review of compensation and ancillary benefits for dependents and survivors, the Commission concluded that those benefits and any cost of living adjustments that would be needed were already covered by the Commission’s recommendations regarding veterans’ compensation and ancillary benefits and obviate further discussion in this chapter. However, it should be understood that these dependents’ and survivors’ benefits must also be brought back to originally intended levels and be automatically adjusted annually to keep pace with the cost of living.

IV Determination Standards for Benefits

The standards for determining VA benefits and services for survivors and other dependents hinges on the eligibility and entitlement status of the disabled veteran. The Commission has enunciated its concerns with the lack of statutory authority to provide families with VA services. It recognizes that once such authority is granted, VA will need to establish rules for providing these services and encourages a fair and equitable regulatory process. At this point, the Commission has addressed issues with existing benefits and services and notes that any changes it has recommended are to be applied to veterans’ families as well, when appropriate. In chapter 7 of this report, the Commission has addressed concerns regarding apportionments and garnishments, which also affects dependents. The other standard that the Commission finds needs further action is the following regarding pending claims.

V Pending Claim Ends with Death

V.1 Issue

A veteran’s claim for VA disability benefits is considered closed when that veteran dies. After death, VA solicits a claim for accrued benefits if there is

²⁰ Ibid, 122.

evidence of a spouse, children, or parents, in that order. These dependents must file an accrued benefits claim within 1 year after the veteran's death, and the claim must be based on the evidence of record in VA possession on the date of the veteran's death. Accrued benefits are those that were due to the veteran but unpaid prior to his death.

Over the past 15 years, courts have consistently held that a veteran's pending claim for benefits is considered closed when the veteran dies. Appeals have been made on behalf of survivors on various grounds, from constitutionality to alleged contradictions within the statutes. In every case, the courts have upheld previous decisions, which render pending claims closed upon the veteran's death.

There are two sections of the U.S. Code which are generally referred to when examining this issue. The first is 38 U.S.C. § 5112 (b)(1), which reads:

(b) The effective date of a reduction or discontinuance of compensation...

(1) By reason of...death of a payee shall be the last day of the month before such marriage, remarriage, or death occurs.

The second is 38 U.S.C. § 5121(a), which reads:

(a) [Periodic monetary benefits] to which an individual was entitled at death under existing ratings or decisions or those based on evidence in the file at date of death (hereinafter...referred to as "accrued benefits") and due and unpaid, shall, upon the death of such individual be paid as follows...

Section 5121(a) goes on to provide the order in which eligible dependents are to be paid any accrued benefits. Court decisions have generally relied on these two sections of the U.S. Code to adjudicate appeals on this issue.

One of the first major court cases which challenged the termination of pending claims upon the veteran's death, and one of the cases most often cited by later decisions, was *Landicho v. Brown*, a 1994 case heard in the U.S. Court of Veterans' Appeals. In its decision, the court held that 38 U.S.C. § 5112(b) (1) specifically provides for the cessation of veterans' disability compensation payments due to the payee's death (*Landicho v. Brown*, 7 Vet. App. 42, 52, § II:A:1 [1994]). Although the law provides a means for payment of *accrued benefits*, disability compensation is specifically terminated upon the veteran's death. Accrued benefits are benefits to which a veteran was entitled on the date of death, but which were not paid. An accrued benefit decision is based on existing ratings or decisions, or evidence on file in VA on the date of death,

including reports of VA hospitalization, reports of private hospitalization, treatment, records, examination authorized by VA, and reports of autopsy.²¹

Subsequent court decisions upheld and expanded upon *Landicho* precedent. The 1998 *Richard v. West*²² decision noted that the “clear intent expressed by the structure and language of the statutory scheme at issue” was to terminate pending claims when the applying veteran dies.

In January of 2007, the U.S. Court of Appeals for the Federal Circuit decided the case of *Padgett v. Nicholson*, in which a veteran’s surviving spouse sought to be substituted for the deceased veteran in an appeal of a disability compensation decision. The court made its decision in two parts. First, it ruled that if a veteran had submitted his appeal for decision to the Court of Appeals for Veterans Claims (CAVC) but died before the court issued its’ decision, it had authority to issue its decision after the veteran’s death. Second, the appeals court held that, in this limited circumstance, a surviving spouse could be substituted for the deceased veteran in the appeal (*Padgett v. Nicholson*. 473 F. 3d 1364, 4–5 [Fed. Cir. 2007]).

The most common argument against altering the status quo is based on the court decisions. The U.S. Court of Appeals for the Federal Circuit has consistently decided that a pending claim is terminated when the veteran dies. Another common argument against changing the law is to point out that the veteran’s survivors are eligible to file a claim for accrued benefits. It is argued that, since the veteran is not available to take medical exams or answer questions about his or her experience, the next best “evidence” is evidence in the VA’s possession at the time of the veteran’s death. Any benefits determined due the veteran but unpaid due to his or her death are paid to the survivors.

Veterans argue that the laws that terminate a veteran’s pending claim at the veteran’s death are unfair to the veteran’s survivors. First, some claim that, for a variety of reasons, many military veterans are reluctant to apply for VA benefits, particularly if they feel that “they will be able to live with [the disability].” It is argued that such a situation takes “inappropriate advantage of [the] member’s reluctance to claim disability compensation.”²³ Second, because “many appeals cases take years to make their way through the system,” it is unfair to prevent survivors from receiving benefits for which they are eligible but which were not granted due to the tardiness of the current system. Third, when medical evidence, possibly new, about the veteran from non-VA medical facilities is

²¹ VA, *Adjudication Procedures Manual*, VIII.3.1.e.

²² *Richard V. West*, 161 F.3d 719 Fed. Cir. 1998

²³ The Military Coalition, Hayden Statement. 10.

critical to the claim but is not in the veteran's file at the time of the veteran's death, it should be considered. Fourth, if the survivors could replace the veteran in the claim or appeal process, VA could save administrative processing time and staffing by not having to repeat the initial claim processing steps, including requesting evidence from the surviving spouse. Claims for accrued benefits must essentially "start over" in the claims process, instead of proceeding from where the veteran's claim was at the time of death. By allowing a survivor to simply continue the original claim, rather than beginning a new claim, VA could save time and resources that could be used to process other claims and appeals.

V.2 Findings

The current system imposes a significant burden on a veteran's family and dependents by not allowing survivors to continue processing the veteran's claim. It can take years for a veteran to advance his or her claim to completion, and requiring that survivors begin this entire process again after the veteran dies is unfair. The veteran's dependents, in order of precedence—surviving spouse, children, and dependent parents—clearly would be appropriate substitutes.

Recommendation 8.3

Allow the veteran's survivors, but not a creditor, to pursue the veteran's due but unpaid benefits and any additional benefits by continuing the claim that was pending when the veteran died, including presenting new evidence not in VA's possession at the time of death.

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Disability Claims Administration

The Commission examined how the policies and operations of VA disability programs were being implemented in the field. The eight site visits that the Commission conducted in 2006 (Appendix D) and much of the testimony heard at Commission meetings formed the basis for the conclusions in this chapter. During the site visits, the Commissioners focused on operations at the regional offices and medical centers of the Department of Veterans' Affairs (VA) and in components of the Department of Defense (DoD) that interact with VA. The Commissioners also focused on the activities of the clinician–examiners who perform medical and physical evaluations of disabled veterans.

I Filing a Claim or Appeal

I.1 Filing a Claim

VA aims to provide timely and accurate decisions on disability compensation claims. Even so, the Department has experienced long delays and extensive backlogs in processing claims for several years. To help overcome the backlog, VA and DoD established a program in 1998 to help service members initiate a disability compensation claim at their military base prior to being discharged. Called Benefits Delivery at Discharge (BDD), the program is in effect at 140 locations in the United States, Korea, and Germany. It currently operates under a 2004 memorandum of agreement between VA and DoD to create a cooperative separation medical examination process to ease the transition from service to veteran status. The BDD program “enables separating service members to file disability compensation claims with VA staff at military bases, complete physical exams, and have their claims evaluated before, or closely following, their military separation.”¹

Claims for disability compensation are initiated when a veteran files an application, either online or at a regional office. A “specific claim in the form prescribed by the Secretary must be filed in order for benefits to be paid or

¹ IOM, *21st Century*, 146.

furnished to any individual under the laws administered by the Secretary” (38 U.S.C. § 5101[a][2006]). However, any communication or action indicating intent to apply for benefits from a claimant or his or her representative may be considered an informal claim (38 U.S.C. § 1155 [2006]).

Upon receipt of a “substantially complete application” (which includes the claimant’s name [veteran or other claimant], his or her relationship to the veteran, sufficient service information for VA to verify the veteran’s service and claimed medical condition or conditions), VA will begin to process the claim. In accordance with the Veterans Claims Assistance Act (VCAA) of 2000, VA has a “duty to assist” the claimant. VA must give the claimant written notification of the evidence that is necessary to substantiate the claim. It must also tell the claimant who is responsible (i.e., VA or the claimant) for obtaining that evidence. VA must make reasonable efforts to obtain relevant records not in the custody of the Federal Government, and it must make as many requests as are necessary to obtain relevant records within the custody of Federal Departments or agencies, including the veteran’s service medical records and VA records of examination or treatment. However, VA encourages applicants to submit copies of their own medical records in order to expedite the claim (Box 9.1 below).

Box 9.1 Excerpt from VA Publication Explaining the Disability Claims Process

What VA Does after It Receives Your Claim

After VA receives your Application for Compensation, it sends you a letter. The letter explains what VA needs in order to help grant your claim. It states how VA assists in getting records to support your claim. The letter may include forms for you to complete, such as medical releases. They help VA obtain pertinent medical records from your doctor or hospital. You should try to complete and return all forms VA sends within a month. Your claim can often be processed more quickly if you send a copy of your own medical records.

What Records VA Obtains to Support Your Claim

VA then attempts to get all the records relevant to your claimed medical conditions from the military, private hospitals or doctors, or any other place you tell us. The person who decides your claim (called a Rating Veterans Service Representative) may order a medical examination. This examination is free of charge. It is extremely important that you report for your examination at the scheduled time to avoid delaying your claim.

SOURCE: IOM, *21st Century*, 148.

I.2 Timeliness of Claims Processing

In 2006, it took an average of 177 days to process claims. During that year, VBA regional offices received over 654,000 claims for disability compensation. Just

over 81 percent of these were reopened claims (claims that were initially denied or the veteran was dissatisfied with the disability rating) and the rest were original claims.

Two-thirds of compensation claims made each year are from veterans previously determined to have a service connected disability most of them are veterans of WWII, Korea, and Vietnam. As the population of veterans ages, VBA can expect to see a growing percentage of claims for worsening chronic conditions. As of June 2007, the average processing days had increased to 181.

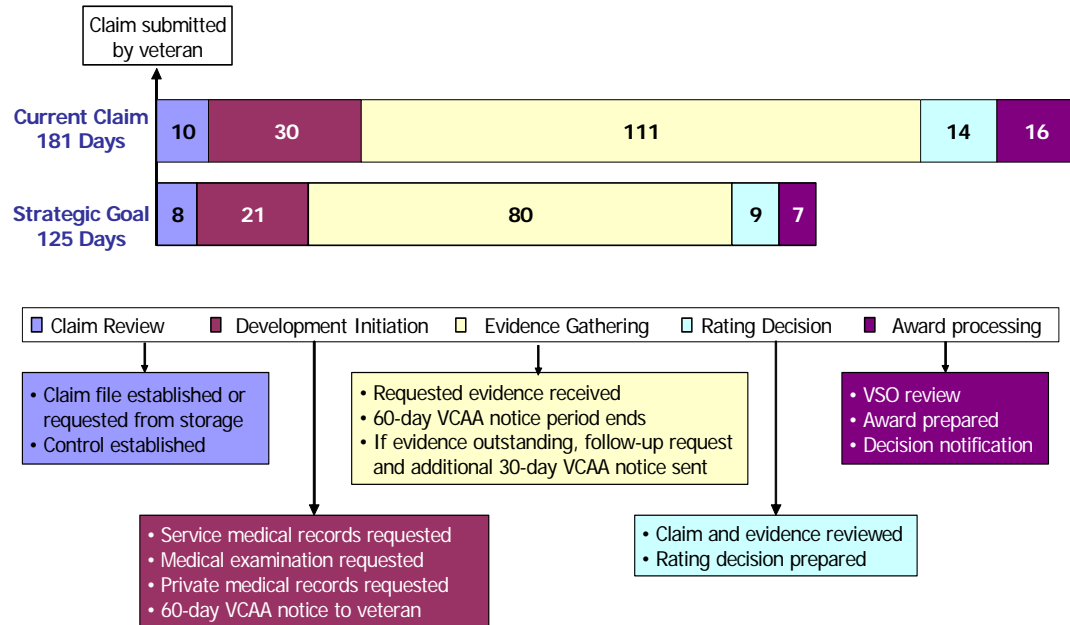
Figure 9.1 shows the average length of time it takes to adjudicate a rating claim for disability compensation benefits in comparison to the strategic goal.²

The development initiation and evidence-gathering phases of disability claims processing take the largest portion of time in the process. The key medical aspects of the disability claims process are:

- development of medical evidence, such as information about degree of impairment, from service showing treatment for claimed disability, from doctors after service linking current disability to service, functional limitation, and disability, which almost always includes a disability examination conducted by a VHA clinician or medical contractor; and
- the rating process, in which the medical evidence is compared with the criteria in the Rating Schedule and a percentage rating is determined.

To analyze the current system for filing a claim (appeals will be addressed separately in this section), the first place to look is the procedure for filing a claim, the forms involved, literature, and so on. When reviewing the present timeline for the timeliness of claims processing, it is evident that the overall process can be reduced if some of the cycles are reduced. The most time-consuming part of claims processing is the time it takes to begin development until the time the development has been received and the claim referred to the rating board for a decision.

² VA, *PA&I Dashboards for FY 2006 (End-of-Month June 2007)*.

Figure 9.1 Disability Claim Timeline (June 2007 Data)

It is noteworthy that most claims filed require VA to further develop evidence when in fact these claimants could have provided VA with more information or evidence from the outset. While most claims are “substantially complete,” they fail to address all the areas required to promote a timely decision by VA. For example, the VA may receive a claim from a veteran who is filing for service connection for a knee condition due to an injury in service (nothing additional written on the claim application submitted by the veteran). It would be deemed minimally sufficient to begin development. However, this claim could have been more effective by stating when and where treatment was received in service, and when and where treatment was received after service up to the present time. Even better would have been if the veteran to provide a copy of the information. The veteran, in this case, could have expedited the decision in his claim by furnishing the evidence the VA would have been obligated to obtain for him. He could have also included a statement requesting VA to make a decision on his claim as soon as VA had received all the evidence, adding that he had no additional evidence to submit.

VA regulations require VA to give all veterans 60 days in which to provide any additional evidence. This regulation is VA's interpretation of a reasonable time frame but was not specified by court decisions or statute. A high percentage of cases could be rated earlier if VA had a statement, signed by the veteran, that he or she had no additional evidence to submit and for VA to make a decision on his or her claim as soon as all the identified evidence had been received. Providing information at the time the claim is filed could obviate the need for VA to wait the 60-day period to see if the veteran replies. VA and veterans service representatives often have to call the veteran in many cases to get this information because all the evidence is already on file, but the 60-day time limit for furnishing additional evidence has not yet passed. In a majority of cases, the veteran states he or she has no other information to submit and requests an early decision. This becomes a resource issue, when the very nature of the issue is to improve the timeliness of claims processing. VA could be devoting more time to claims processing if a claim was well documented at time of filing. Having a well-documented claim presented at the beginning of the claims process still significantly reduces the time it takes to decide a claim. It should also be noted that VA will not violate a veteran's right to file a claim or to furnish information. If a veteran does not want VA to make an early decision for any reason, VA will wait for the 60-day time limit to mature. VA's responsibility in this case would be to obtain the service medical records and also to schedule a VA exam if the evidence warranted it.

In the development initiation and evidence-gathering phases, VA cannot proceed without acquiring the evidence that was identified by the veteran. If there has been no reply to prior requests, VA must send a second request for the evidence. Clearly, if this stage could be shortened, the overall claims process would be shortened, and VA would be in a better position to provide timely decisions to veterans and reach their strategic goal of processing disability claims within 125 days of receipt.

Multiple requests are often necessary to obtain needed information. This phase of the claims process is managed by the predetermination team in the Veteran Service Center. The team sets diaries (deadline dates) for receipt of requested information, then determines the need for a VA medical examination to determine current level of disability or to provide a medical opinion as to whether the current disability is related to the veteran's military service (referred to as "medical nexus").

According to VA, "The purpose of compensation and pension (C&P) examinations is to provide the medical information needed to reach a legal decision about a veteran's entitlement to VA monetary benefits based on disability" (Brown, 2003). Obtaining a C&P medical examination is part of VA's duty to assist the applicant. An examination is required:

- when a veteran files a claim for service connection and submits evidence of disability;
- when a veteran asserts a worsened service-connected condition;
- to provide medical nexus;
- to reconcile diagnoses;
- as directed by the Board of Veterans Appeals (BVA); and
- as required by regulation (Pamperin, 2006).³

In 2004, VA began fielding online examination templates for each of the Automated Medical Information Exchange worksheets in graphical user interface format. These “intelligent,” point-and-click templates are designed to structure the information gathering and reporting process, thus increasing completeness, consistency, and timeliness of examination reports. As of April 2005, a version of each of the automated templates was installed in all examination sites.⁴ The templates had been used 290,000 times as of the end of February 2007 and accounted for about 28 percent (21,125 of 75,000) of the C&P examinations performed by VHA that month. Of 102 sites using the templates, 59 completed more than 1,000 in January 2007. According to the director of the Compensation and Pension Examination Program (CPEP), VA is committed to mandating template use, and key stakeholder feedback and refinement activities are underway prior to taking that step.⁵ If an examination report does not include sufficiently detailed information to support the diagnoses or about the effects of diagnosed conditions on functioning, the rating veterans service representative (RVSR) is instructed to return the report as inadequate for rating purposes.⁶

After all development actions are complete, the claim is referred to the RVSR for a rating. The RVSR reviews all the evidence associated with the claim, makes decisions on issues raised by the claimant, and identifies any inferred issues that should be addressed. The RVSR documents the rating decision in a standard format, using an automated rating preparation system called Rating Board Automation 2000. After completing the rating decision, the claims folder with the rating is referred to the postdetermination team (PDT) for processing of the decision. Prior to releasing the claims folder and the rating to the PDT, and if the veteran has retained a veteran service organization, one of their representatives will review the rating and initial the rating if they agree. The claims folder and rating then go to the PDT. If the PDT does not agree with the decision, the rating is sent back to the RVSR and both the VSO and RVSR will confer about the rating.

³ IOM, *21st Century*, 148.

⁴ *Ibid.*, 150.

⁵ *Ibid.*, 150.

⁶ *Ibid.*, 152.

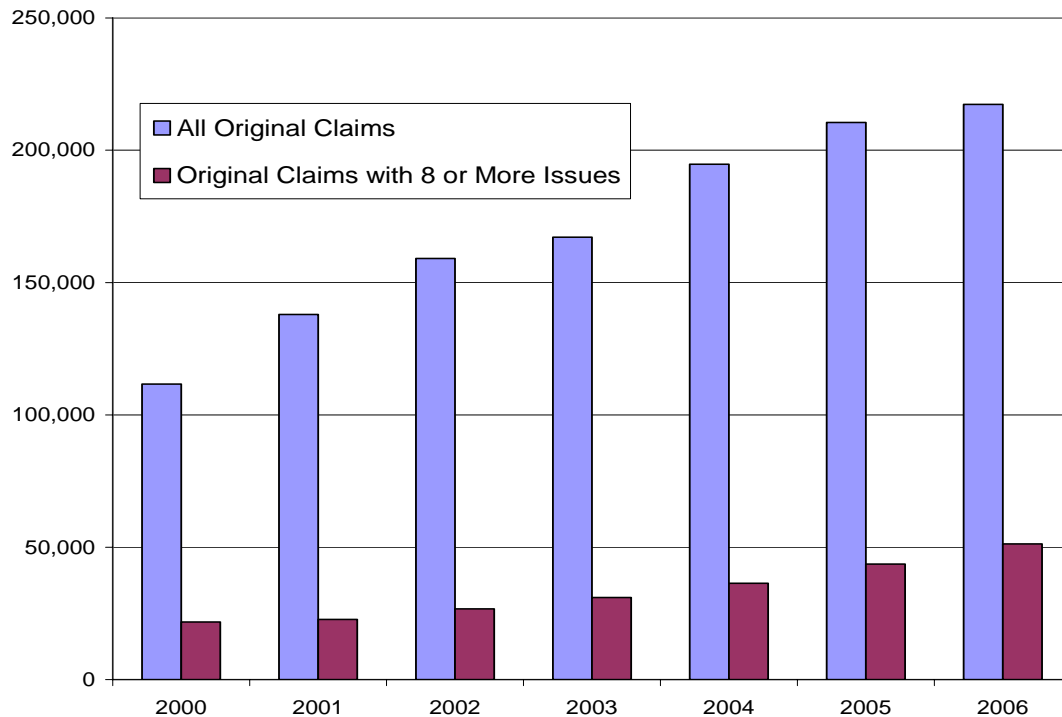
I.3 Volume of Claims

The number of disability claims pending and the time it takes VA to process those claims has been a growing concern among veterans, veterans' service organizations, VA, Congress, and stakeholders. The bar graphs below (Figures 9-2, 9-3, and 9-4) reflect information on original claims received, the number of rating-related claims filed and decided, and the number of claims pending and the number pending more than 6 months, respectively from FY 2000 through FY 2006.⁷

In FY 2006, VA received 806,000 disability-related claims. Most of these (654,000) were claims from veterans for compensation for service-connected injuries and diseases. (The other disability-related claims were for disability pension, dependency and indemnity compensation for survivors, hospitalization reviews, and future examination reviews.) Compared with the FY 2000 workload, this was a 38 percent increase in disability-related claims and a 56 percent increase in compensation claims (VA, 2006). In addition, the number of claims involving eight or more issues (i.e., medical conditions), each of which must be evaluated separately, has more than doubled, from about 21,000 (20 percent of the original claims) in 2000 to about 51,000 (22 percent of original claims) in 2006 (Figure 9.3). This means that the number of rating decisions that must be made was a multiple of the 654,000 disability compensation claims filed in FY 2006.

⁷ Ibid., 170-172.

Figure 9.2 Number of Original Compensation Claims from Veterans and Number of Original Compensation Claims from Veterans Containing Eight or More Issues, End of FY 2000–2006

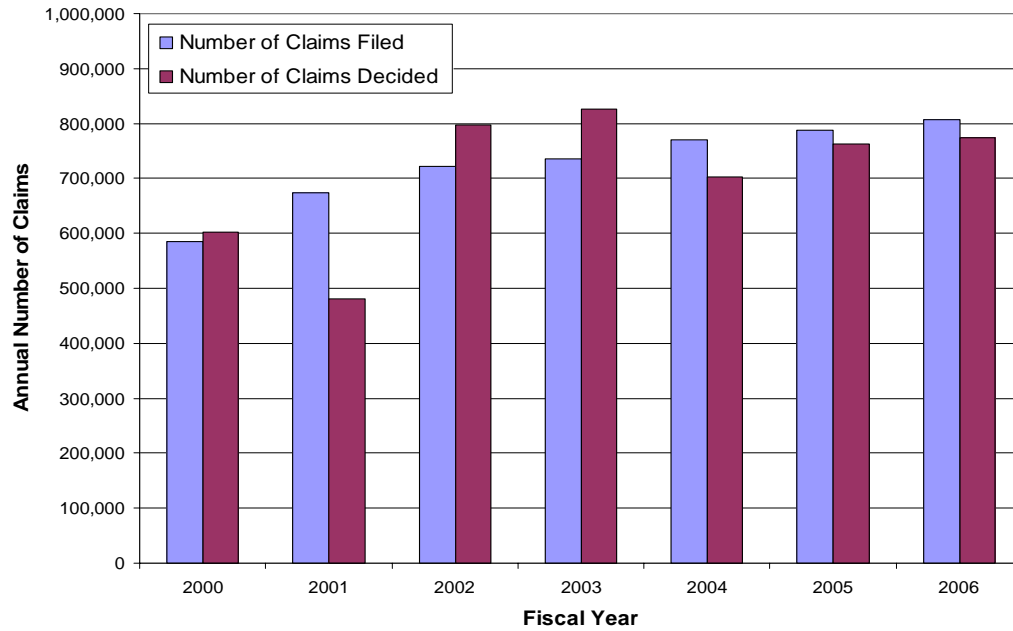


SOURCE: IOM, *21st Century*, 170.

VBA has been unable to track total number of issues adjudicated until recently with the advent of the current tracking system, RBA 2000. According to data provided to the committee by VBA, adjudicators made more than 1.8 million rating decisions on compensation for disabilities during calendar year 2006 while adjudicating 628,000 disability compensation claims, indicating that the average number of issues (disabilities) per claim was just under three.

As the annual number of ratings-related claims filed has increased, so have the number of decisions on rating-related claims (Figure 9.4).

Figure 9.3 Number of Rating-Related Claims Filed and Decided, FY 2000–FY 2006

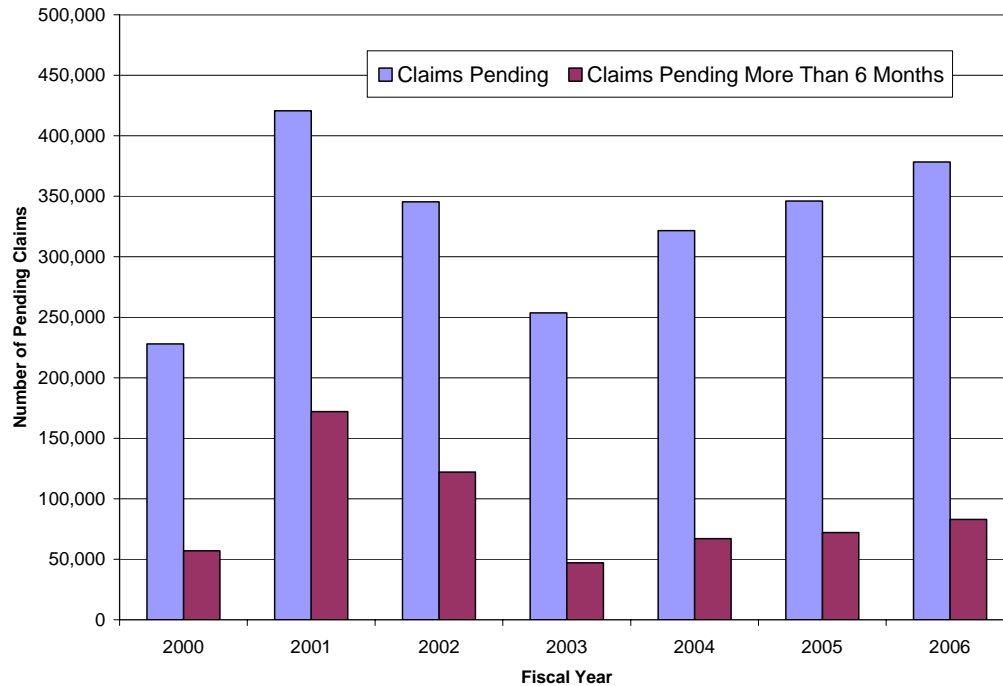


SOURCE: IOM, *21st Century*, 171.

However, new claim receipts continue to exceed case dispositions, resulting in an increasing backlog of pending claims. Nearly 380,000 rating-related claims were pending at the end of FY 2006, compared with 228,000 at the end of FY 2000 (Figure 9.5).⁸

⁸ Ibid., 169.

Figure 9.4 Number of Rating-Related Claims Pending and Number Pending More Than Six Months, End of FY, 2000–2006



SOURCE: IOM, *21st Century*, 172.

I.4 Filing an Appeal

A veteran (or other applicant, such as a surviving spouse, child, or parent of a veteran) who disagrees with a VA regional office's decision can file an appeal either to the local regional office (for reconsideration of the original decision) or to the Board of Veterans Appeals (BVA). If the veteran chooses to appeal to the regional office, but is still dissatisfied with the decision, he or she may then appeal to a local decision review officer (DRO), stationed at the regional office. If the appeal is still not satisfactorily resolved, the veteran may appeal to BVA.

If still dissatisfied, the veteran has additional appeals (in sequential order) to:

- the U.S. Court of Appeals for Veterans Claims;
- the U.S. Court of Appeals for the Federal Circuit; and
- the U.S. Supreme Court.⁹

Although a veteran can appeal for any reason, issues frequently appealed include disability compensation, pension, education benefits, recovery of overpayments, and reimbursement for unauthorized medical services. The two most common appeals are made by veterans who feel that (1) the VA regional

⁹ Ibid., 157.

office denied them benefits for an impairment (i.e., it was declared not to be service connected) that they believe began while they were in service, and (2) the severity rating assigned to the impairment was too low and an increase in the rating level is warranted.¹⁰

I.4.A Appeal Steps

To begin the appeal process, a veteran files a written notice of disagreement with the field office (regional office or medical center) from which the disputed decision was issued. For most compensation cases, the appeal must be filed within 1 year from the date of the decision. If more than one claim is at issue (e.g., a claim for compensation based on an orthopedic condition and a claim for compensation on a respiratory condition), the notice of disagreement must be specific about which issue or issues are being appealed. If a veteran is appealing to the regional local office (rather than BVA), he or she may choose to have the case handled in the traditional appellate review process (in which an RVSR handles the appeal) or to have the file reviewed by a decision review officer (DRO). DROs provide a second (*de novo* or a brand new decision, rather than reviewing the prior decision) review of an appellant's entire file, and they can hold a personal hearing about an appellant's claim. DROs are authorized to grant the contested benefits based on the same evidence in the claim folder that the local office used to make the initial decision. After completing any additional development or proceedings, the RVSR or DRO (as appropriate) sends the veteran either a favorable decision on all issues, or a statement of case explaining the reasons for the decision not to allow the appeal (this may include granting one or more of the appealed issues), along with VA Form 9, the substantive appeal form, which the veteran may use to ask for a BVA review of the decision. VA Form 9 must be filed within 60 days of the mailing of the statement of case, or within 1 year from the date VA mailed its decision, whichever is later. (The 60-day period for filing a substantive appeal can be extended for "good cause.")

On Form 9, the veteran states the desired benefit, notes perceived mistakes in the statement of case, and comments on anything with which he or she disagrees. If the veteran submits new evidence or information with the substantive appeal, such as records from recent medical treatments or evaluations, the VA local office prepares a supplemental statement of case, which is similar to the statement of case, but addresses the new information or evidence submitted.

The local VA office sends a letter to the veteran who files an appeal to BVA when the claims folder is transferred to BVA in Washington, DC. Generally, the

¹⁰ Ibid., 157-158.

appellant has 90 days (from the date of the letter) or until BVA decides his or her case, whichever comes first, during which to submit more evidence, request a hearing, or select or change a representative.

At personal hearings, appellants meet with either a DRO at the regional office or a BVA member (at BVA hearings). Personal hearings are informal. Appellants in most areas of the country can choose to hold a BVA hearing. The most common BVA hearing is where the appellant is at the regional office and the member of BVA travels to the regional office. This is called a travel board hearing. The appellant can also go to Washington and have a hearing with the member of BVA at the BVA office in Washington, DC. Some regional offices are also equipped to hold BVA hearings by videoconference with the appellant at his or her regional office and the board member in Washington, DC, which is considered the most expedient choice.¹¹

After the hearing, a BVA board member will review a transcript of the hearing and the appellant's file and make a decision either allowing or denying the case. Appeals may be dismissed in certain limited circumstances. However, if BVA cannot make a final decision, it may remand the case (i.e., send the claim back to the Appeals Management Center or regional office, depending on workload) for additional development and a new determination. If after completing the additional development, the local office is again unable to allow the claim, it returns the case to BVA for a final decision.¹²

I.4.B Board of Veterans' Appeals

BVA is a quasi-judicial, organizationally independent component of VA that reports directly to the VA Secretary and makes final agency decisions with respect to claims for veterans' benefits. BVA reviews all appeals for entitlement to veterans' benefits on behalf of the VA Secretary, including appeals involving claims for service connection, increased disability ratings, individual unemployability, pension, insurance benefits, educational benefits, home loan guaranties, vocational rehabilitation, and dependency and indemnity compensation, and also determinations of duty status, marital status, dependency status, and effective dates of benefits.

The law requires BVA to decide cases on a "first come, first served" basis. To do that a docket number in the order in which the substantive appeal is received. An appellant may file a motion to advance the case if he or she believes that his or her appeal should be decided sooner than the appeals of others.

¹¹ *Ibid.*, 159.

¹² *Ibid.*, 159.

BVA decides cases *de novo* (that is, it makes a brand new decision, rather than reviewing the prior decision), so it gives no deference to the regional office decision being appealed. Decisions are based only on the law, VA's regulations, precedent decisions of the courts, and precedent opinions of VA's general counsel. BVA performs an analysis of credibility and probative value of evidence and considers all potentially applicable provisions of law and regulations. Final decisions must include:

- findings of fact;
- conclusions of law;
- analysis of the reasons and bases for the decision on each material issue of fact and law; and
- an order granting or denying the appeal.¹³

In the event that an appellant is dissatisfied with a final BVA appeals decision, he or she has several options:

- accept the decision and take no further action, in which case the decision becomes final;
- go back to the regional office and with new and material evidence, try to reopen the claim;
- file a motion for reconsideration or to vacate (i.e., an attempt to have the same body withdraw or modify its decision) with BVA;
- re-review the case because there was a clear and unmistakable error in the BVA decision; or
- file an appeal with the U.S. Court of Appeals for Veterans Claims.

I.4.C U.S. Court of Appeals for Veterans Claims

If BVA denies requested benefits, or it grants less than the maximum benefit available under the law, and the appellant decides to appeal to the U.S. Court of Appeals for Veterans Claims (CAVC), he or she must file the appeal within 120 days after BVA mailed its decision. Unlike BVA, CAVC does not receive new evidence. CAVC considers only:

- the BVA decision;
- briefs submitted by the appellant and VA;
- oral arguments, if any; and
- the case record (the entire claims folder) that VA considered and that BVA had available.

¹³ Ibid., 159-160.

In cases decided on merit (cases not dismissed on procedural grounds), the court may (1) reverse the BVA decision (i.e., grant contested benefits); (2) affirm the BVA decision (i.e., deny contested benefits); or (3) remand the case back to BVA for rework.¹⁴

I.4.D U.S. Court of Appeals for the Federal Circuit and the U.S. Supreme Court

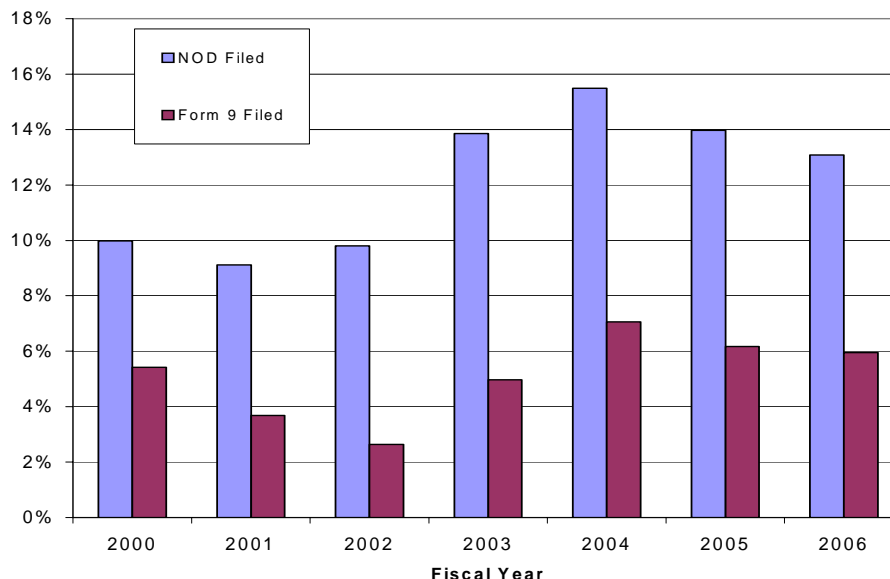
Under certain circumstances, an appellant or VA who disagrees with a decision of the Court of Appeals for Veterans Claims may appeal to the U.S. Court of Appeals for the Federal Circuit and then to the Supreme Court of the United States.

The court reviews the same record that was considered by BVA; that is, the court does not receive new evidence nor does it hold a trial. Appellants themselves or their lawyers or approved agents may serve as representatives before the court; however, the court directs whether oral argument is held. Either the appellant or VA may appeal a decision made by the U.S. Court of Appeals for Veterans Claims to the U.S. Court of Appeals for the Federal Circuit, and may seek further review in the Supreme Court of the United States.

The number of appeals pending and the time it takes VA to process those appeals has been a growing concern for decades among veterans, veterans service organizations, VA, Congress, and others associated with the appeals process. The bar graphs below (Figures 9-6 through 9-10) reflect information on appeals received, pending, and decided from FY 2000 through FY 2006.¹⁵

¹⁴ Ibid., 164.

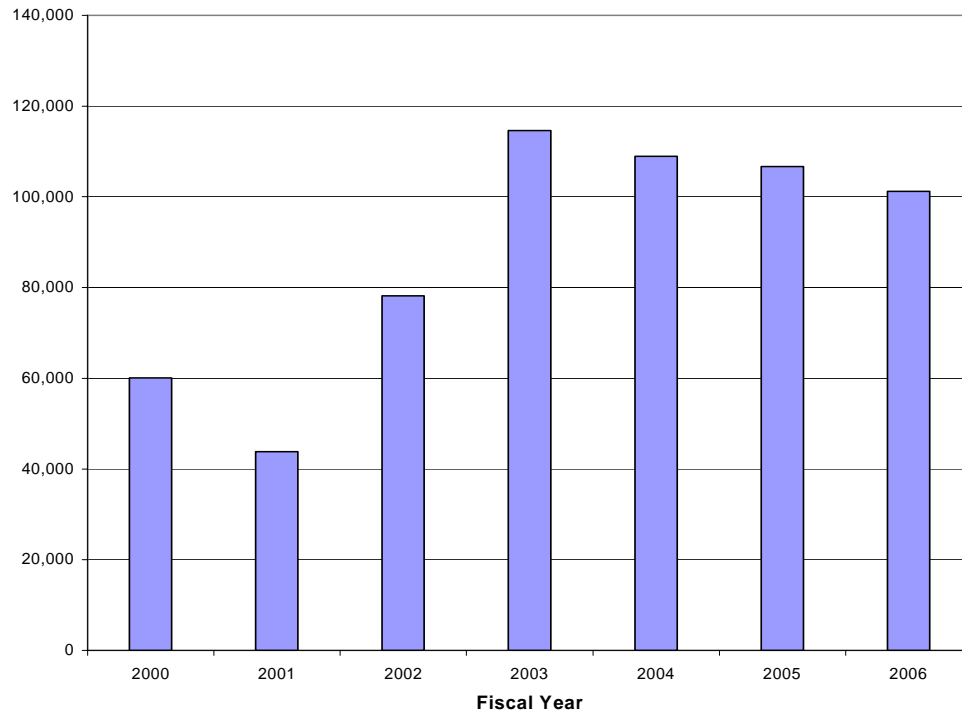
¹⁵ Ibid., 143–148.

Figure 9.5 Rate of Appeals (Notices of Disagreement), FY 2000–FY 2006

SOURCE: IOM, *21st Century*, 175.

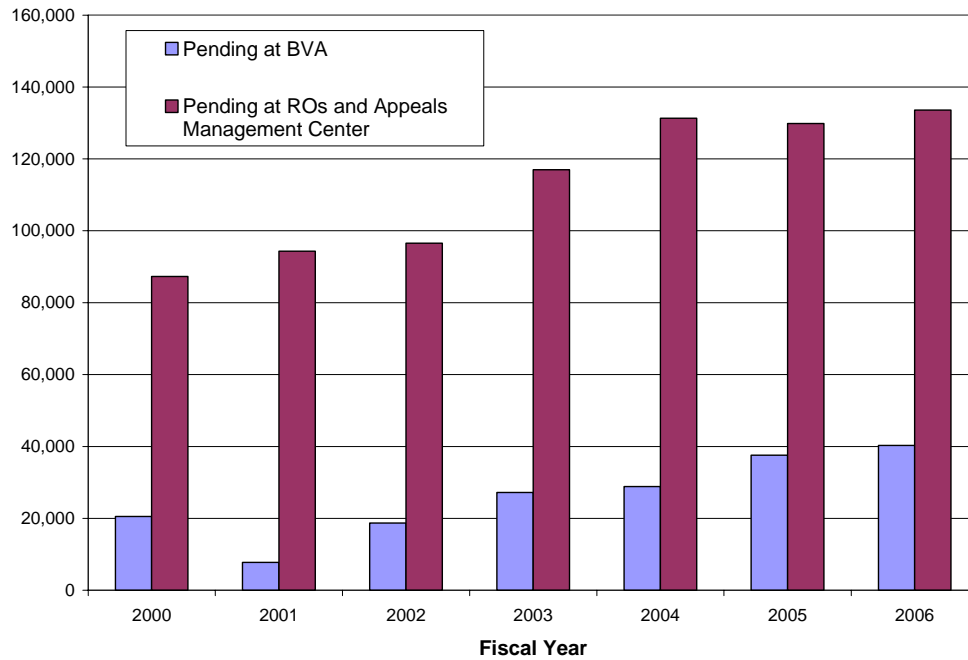
Many notices of disagreement are resolved by the regional office or when the appellant does not pursue the appeal, but the number of formal appeals was still higher in FY 2006 than in FY 2000. Appellants filed 46,100 formal appeals in FY 2006 compared with 32,600 formal appeals in FY 2000. The annual number of BVA decisions, however, has not increased. As a result, the number of cases pending at BVA at the end of FY 2006—40,265—was almost double the number at the end of FY 2000. This does not include the substantial number of appeals being worked on by the appeals teams in regional offices and the Appeals Management Center, which had been established by the Veterans Benefits Administration (VBA) in 2003 to consolidate expertise in processing remands from BVA (Figure 9.8).¹⁶

¹⁶ Ibid., 174.

Figure 9.6 Number of Appeals (Notices of Disagreement), FY 2000–FY 2006

SOURCE: IOM, *21st Century*, 175.

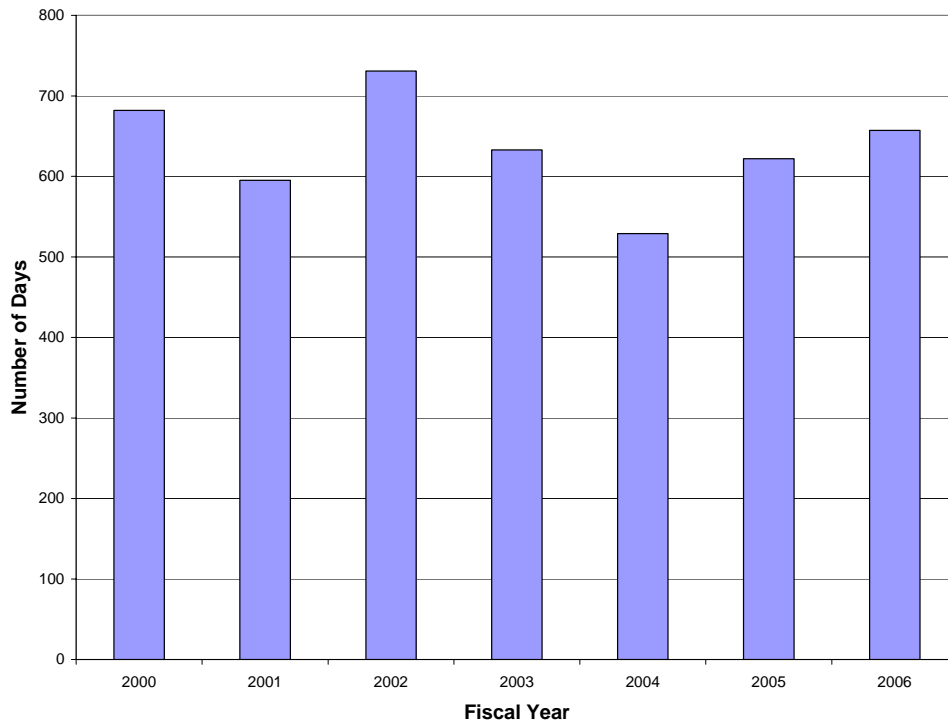
Figure 9.7 Number of Appeals Pending at BVA and at Regional Offices (ROs) and the Appeals Management Center, FY 2000–FY 2006



SOURCE: IOM, *21st Century*, 176.

The average number of days it took to resolve appeals, either by the Veterans Benefits Administration or the Board of Veteran Appeals, was 657 days in FY 2006. This continued a steady increase since FY 2003, but was better than the 731 days it took in FY 2002 (Figure 9.9).

Figure 9.8 Average Number of Days to Resolve Appeals (i.e., Appeals Resolution Time), FY 2000–FY 2006



SOURCE: IOM, *21st Century*, 177.

Note: Appeals resolution time is a joint BVA-VBA measure of time from receipt of notice of disagreement by VBA to final decision by VBA or BVA. Remands are not considered to be final decisions in this measure. Also not included are cases returned as a result of a remand by the U.S. Court of Appeals for Veterans Claims.

Most appeals (72 percent in FY 2006) are resolved without a hearing before BVA. In FY 2006, 22,000 cases were resolved at the field office level after the notice of disagreement was received but before a formal appeal was filed on VA Form 9. In 42,200 cases, the appellant decided not to appeal further after reading the field office's statement of the case. Another 11,000 were resolved at the field office level after Form 9 was submitted. That left 29,000 appeals, of which BVA resolved 25,000 and remanded 4,000 to the field offices for further development.¹⁷

BVA decided 39,100 cases specifically involving disability compensation in FY 2006. It upheld the field office denials 46 percent of the time, reversed the field office decision on one or more of the issues 20 percent of the time, and

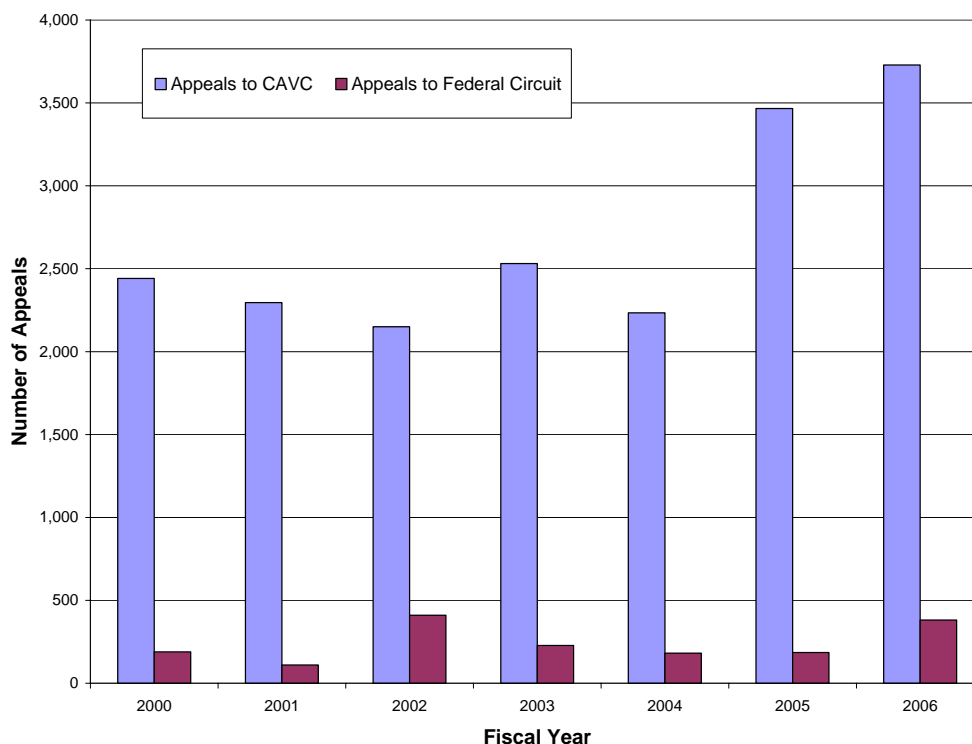
¹⁷ *Ibid.*, 174.

remanded the case to the originating field office 32 percent of the time for further development of one or more issues.¹⁸

The number of appeals to the U.S. Court of Appeals for Veterans Claims averaged between 2,000 and 2,500 a year before FY 2005, when it jumped to 3,500 (Figure 9.10). The Court of Appeals for Veterans Claims received 3,700 appeals in FY 2006. This court affirmed the BVA decision in full or in part in 11 percent of the cases in FY 2004, 16 percent in FY 2005, and 25 percent in FY 2006. During the same 3 years, the same court reversed the BVA decision or remanded the case for further development 50–60 percent of the time.¹⁹

There were 382 appeals to the Federal Circuit Court in FY 2006, the highest since FY 2002, when 410 appeals were filed (Figure 9.10).

Figure 9.9 Annual Number of Appeals of BVA Disability Decisions to the Courts, FY 2000–FY 2006



SOURCE: IOM, *21st Century*, 178.

¹⁸ Ibid., 174-176.

¹⁹ Another 25–35 percent were dismissed on procedural grounds.

I.4.E Remands and Timeliness

Remands are of concern because not only do they increase the time it takes for a decision on the individual veteran's claim by at least a year, they also increase the overall workload and slow the resolution of appeals of other appellants. By law, BVA must decide on appeals in the order in which they were entered on the docket. If BVA remands a case to the regional office, and that case is subsequently returned to BVA for a decision, which happens about 75 percent of the time, the returned case takes precedence over appeals currently before BVA. During FY 2006, BVA remanded 32 percent (12,500) of the cases it decided. At the end of FY 2006, 16 percent (21,200 of 133,600) of the rating-related claims pending at regional offices and the Veterans Benefits Administration's Appeals Management Center were remands. If, as expected, 75 percent of the remands are returned to BVA after further development, they will constitute 30–40 percent of the 35,000–40,000 cases decided by BVA each year (in FY 2006, for example, BVA received 14,400 remands returned by the Appeals Management Center and regional offices for decision, equal to 37 percent of BVA decisions that year (Figure 9.11).²⁰

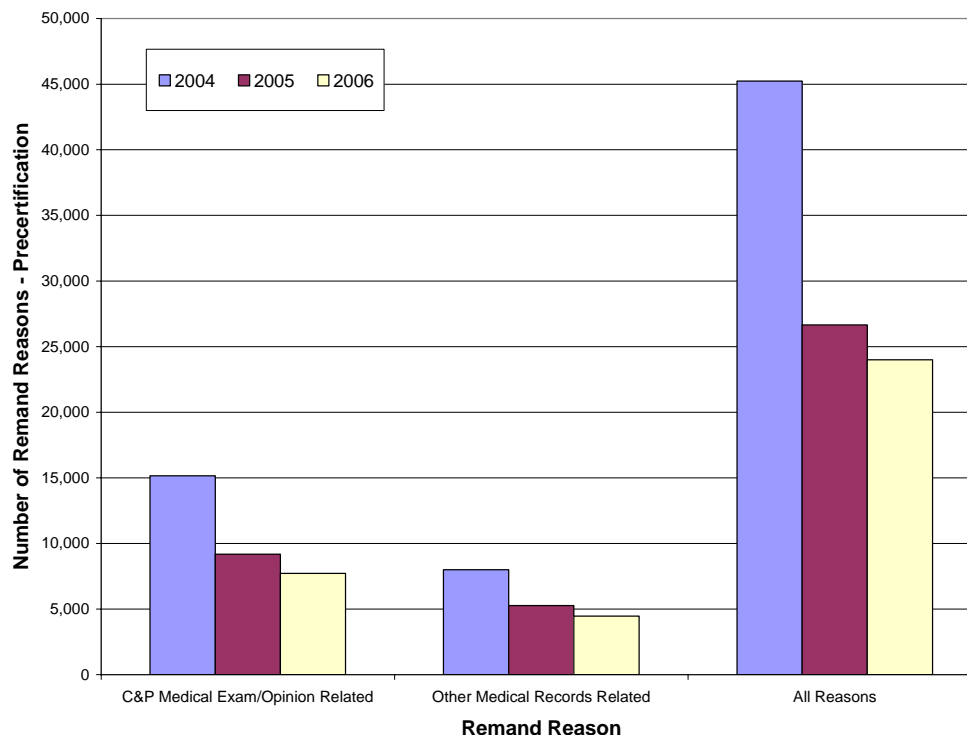
The percentage of BVA dispositions remanded jumped from 30 percent in FY 2000 to 49 percent in FY 2001. In 2002, in response to a recommendation of the 2001 Claims Processing Task Force, BVA established an evidence development unit to develop evidence needed to make a final decision or correct a procedural error in cases that otherwise would have to be remanded. The remand rate fell to about 15 percent "within a matter of months".²¹

When evidence development by BVA was barred by the U.S. Court of Appeals for Veterans Claims, the Veterans Benefits Administration created the Appeals Management Center in July 2003 to specialize in developing the cases that have been remanded by BVA and reviewing the regional office.²²

²⁰ IOM, *21st Century*, 177-178.

²¹ *Ibid.*, 178.

²² *Ibid.*, 178-179.

Figure 9.10 Number of Remands by Reason, FY 2004–FY 2006

SOURCE: IOM, *21st Century*, 180.

Note: Other medical records include military service, VA, and private medical records that should have been requested but were not, or if requested but not forthcoming, were not followed up. Nonmedical reasons for remands have to do with duty to notify (lack of, incorrect, or inadequate notices to appellants), duty to assist (not obtaining nonmedical service and other records), and due process (not following procedural rules).

I.5 Reports that Have Evaluated the Claims and Appeal Process

I.5.A Report of the President's Commission on Veterans Pensions (Bradley Commission)

The 1956 Bradley Commission noted that "(t)imely and adequate assistance must be provided to alleviate the war-incurred handicaps of servicemen as soon as possible after separation."²³ Furthermore, "(t)he timely assistance that was provided to World War II and Korean conflict veterans was a major step toward the solution of the veterans' problem—a problem that faced this country after each preceding conflict but remained unsolved until World War II."²⁴

²³ President's Commission, *Report*, 11.

²⁴ *Ibid.*, 29.

I.5.B Report of the Veterans' Claims Adjudication Commission (VCAC)

The Veterans' Claims Adjudication Commission (VCAC) noted that the VA claims and appeals system is "perceived as inefficient, untimely, inaccurate, and so on."²⁵ The commission looked to Congress to "decide whether the existing benefits, concomitant processing system, and the level of performance, is proximate to what it wants and intends."²⁶ The commission analyzed pending and completed original and reopened disability compensation claims and pending appeals.

One of the noteworthy findings was the length of time it took VA to develop a claim. Based on a random sample of claims from six regional offices, for original claims it took, on average, 23 days from date of receipt until the regional office's first request for development information. The regional offices' elapsed time for development was 107 days, on average. The average time from completion of development to regional office decision was 80 days. For repeat claims, it took regional offices, on average, 48 days from date of receipt until the first request for development information. Elapsed development time was 73 days. The average time from completion of development to regional office decision was 95 days.²⁷

VCAC found that regarding timeliness of a request for evidence, most veterans responded to requests for information timely or not at all. Veterans did not respond 35.1 percent of the time (13 cases). In 75 percent (15 of 20) of the remaining cases, the veteran responded in 30 days or less.

Third-party requests, such as private physician reports and VA medical records, were also received on time, with 73.7 percent (14 of 19) received in 30 days or less. The commission found in receiving comments from veterans that "[t]he claims application process is very complex and frustrating to veterans. The application form is in need of serious revision both for ease of use by veterans and by adjudication division employees. Veterans need more information about what evidence is required to support a claim and how to get it. They also need better information about the steps in the claims process, how long an average claim should take, and how long their claim will take if different from the average."²⁸ As with many reports on claims processing, the commission encouraged strong VA–veteran service organization partnerships. They noted case management to be "a promising claims-processing technique.

²⁵ VCAC, *Report*, 26.

²⁶ *Ibid.*, 26-27.

²⁷ *Ibid.*, 65.

²⁸ *Ibid.*, 127.

VCAC said “A fully documented claim presented to VA can be readily decided. Some regional offices have agreements with veterans service organizations under which a well-documented claim presented to the regional office will be adjudicated immediately. These agreements demonstrate the mutual benefits of building partnership between claimants, representatives, and VA.”²⁹

The VCAC held a focus group meeting of VA employees. “Employees said veterans do not know what happens to their claims because VA does not explain the application process well. One employee said he did not understand the process, so how could a veteran?”³⁰ VA employees reported that veterans who were assisted in filing a claim or appeal by either a VA benefits counselor or a veterans service representative filed better, well-documented, claims. They acknowledged the value of service representatives.

VCAC’s major findings and recommendations for the claims and appeals process were:³¹

- it involves too many handoffs at the initial adjudication level;
- it lacks clear and definitive rules that can be fairly and efficiently applied to the processing of the vast majority of cases;
- it fails to provide meaningful due process to claimants by not making them partners in the adjudicative process;
- it imposes time-consuming and labor-intensive redundancies, such as, the notice of disagreement and statement of the case prior to the filing of a formal appeal;
- it blurs accountability due to ill-defined jurisdictional lines and failure to use the results of actual adjudications for quality control and employee rating purposes; and
- it generally fails to treat the claims and appeals process as a continuum that should narrow and sharpen issues as a claim proceeds through the process, rather than expanding and obfuscating them.

VCAC also recommended “replacing the notice of disagreement with a formal appeal and eliminating the statement of the case; shortening the appeal period to 60 days; expanding the role of the hearing officers to make it the mandatory first step in the appeal process.”³²

²⁹ Ibid., 204.

³⁰ Ibid., 137.

³¹ Ibid., 181.

³² Ibid., 185.

Filing an appeal on a VA decision is not difficult and the process is well documented. What is not easy or well understood is why it takes so long to resolve that appeal. The delay in processing appeals is well known to all associated with the appeals process. At the regional office level, the appeals process is very tedious and utilizes many resources that could be processing claims. VCAC discussed appeals processing in great detail. A notice of disagreement with a regional office decision initiates the appeals process. A statement of the case is usually issued by the regional office, and the veteran is requested to file a substantive appeal if he or she is not in agreement with the original decision. The veteran is asked if he or she would like to have a decision review officer (DRO) review the case and is also given the opportunity to have a hearing with the DRO. The DRO will issue a decision, and if the decision is unfavorable, the veteran can continue the appeals process and the case will ultimately be sent to the Board of Veterans Appeals (BVA).

I.5.C Report of the VA Claims Processing Task Force

This 2001 Task Force recommended ways to improve the timeliness of claims and appeals processing. One of their recommendations was to “Revise the operating procedures in *Veterans Benefits Administration Manual (M21-1)*: Evidence requested from a claimant, private physician, or private hospital must be received within 30 days.”³³ Regional offices allow claimants 60 days from the date of request to submit requested evidence.

Reducing the time limit to submit evidence from 60 to 30 days will significantly assist the Veterans Benefits Administration in meeting their processing goal of 100 days. Under VA regulations, a claimant has 1 year from the date of request of the information in which to submit that evidence. Therefore, the date of entitlement is still protected by the “1-year rule” so veterans will not be harmed by this recommended change.³⁴

For appeals, the Task Force recommended changing processes to “Require that BVA process the current workload of appeals, including development of appeals, rather than issuing remands. The Veterans Benefits Administration should return BVA remands for priority processing. Priority should be given to working the approximately 1,800 cases that were remanded prior to FY 1998.”³⁵

Acceptance of new evidence should occur only at the BVA level. Cases should not be remanded because of new evidence subsequent to the date the appeal was sent to BVA. An organizational realignment is required by the Veterans

³³ VA Claims Processing Task Force. *Report*. Washington, DC: VA, 2001, 32.

³⁴ *Ibid.*, 33.

³⁵ *Ibid.*, 34.

Benefits Administration to support the BVA remand and decision process. The Veterans Benefits Administration should place an appeal decision-processing unit within BVA to support the appeals process and to reduce, if not eliminate, remands. Establish a method of accountability for BVA in developing cases for decision rather than returning the appeals to the regional offices. Continue to track errors that result in remands for cause and report on the type and rate of errors to the originating office for quality and retraining purposes. Transfer responsibility for processing Veterans Health Administration (VHA) appeals and remands in an expeditious manner to VHA.

Training was recommended for regional office claims development staff in records retrieval. The training should focus on identifying key veteran service information to aid the searcher, and the availability of certain service information in VA systems. The training must strongly emphasize the need to address all issues in the initial request to the National Personnel Record Center.³⁶

I.5.D Report by the Institute of Medicine

Veterans deserve a claims process that is efficient and fair. They should not have to wait long for decisions on disability compensation and other benefits. The decisions should accurately determine eligibility to minimize the number of false negatives (veterans incorrectly denied benefits) and false positives (veterans granted benefits for which they are not eligible). Veterans with similar levels of disability should be treated the same even if they are dealing with different regional offices. And if they appeal, they should receive an accurate decision within a reasonable amount of time.³⁷

The VA claims process has long struggled with timeliness, accuracy, and consistency. The importance of adequate medical examinations in achieving timeliness, accuracy, and consistency has been recognized since the early 1990s. But, the most important factor affecting VA's ability to produce timely, accurate, and consistent decisions is the disability claim workload.³⁸

I.5.E Report by The CNA Corporation

The CNA Corporation (CNAC) was tasked with comparing the VA Disability Compensation Program with other federal disability programs and to explore lessons learned from other disability programs. The analysts interviewed VA staff and reviewed reports from the Government Accountability Office (GAO), VA Office of the Inspector General, Commission site visit summaries, and congressional testimony. CNAC reported processing claims for disability compensation took an average of 177 days in FY 2006. Accuracy and consistency were reviewed and reported as 86 percent of decisions reviewed. It

³⁶ Ibid., 47.

³⁷ IOM, *21st Century*, 166.

³⁸ Ibid., 166.

was noted that decision making was accomplished at 57 regional offices all across the country. One of the findings from the raters and veterans service organization survey was that it was often time consuming to receive evidence, thus contributing to the delay in providing timely decisions to veterans. CNAC reported VA compared favorably with other federal programs except in the area of timeliness. They also noted training and turnover are key to the success of any claims program.

I.6 Perspectives on Claims and Appeals from Commission's Site Visits

During site visits, the Commission heard from Veterans Service Center employees. Employees provided the Commission teams with a perspective on their operational challenges to include the difficulty in creating Veterans Claims Assistance Act (VCAA) letters, demands for productivity, the need for training, high turnover rates and the time it takes to train new raters, communication with veterans service organizations and examiners, frivolous claims, and the development of claims with multiple conditions or issues. VA raters said that templates should be made mandatory at all VA locations where compensation and pension examinations are conducted. All site visits included town hall meetings, which afforded the Commissioners a chance to meet and hear from veterans about some of the issues that were important to them. One of the most common complaints was the difficulty in filing and understanding claims and appeals. Veterans found the process too complex and frustrating.

One program from the site visits that merits consideration as a best practice is the Washington Department of Veterans Affairs (WDVA) Claims Quality Assurance (QA) initiative. WDVA demonstrated an innovative, performance-based system developed to measure and improve the quality of claims submitted to VA by veteran service officers in the state.

In 2005, WDVA filed 9,933 claims for benefits on behalf of veterans in the state of Washington. (The majority of the claims work performed by the WDVA is accomplished through contracts with the major veteran service organizations.) Just prior to initiating the Claims QA program, WDVA conducted a random sampling of these claims using the new system's performance measures and scoring. The claims in the preprogram sample scored a 48 percent "batting average" in quality of claims submitted. One year after the introduction of the Claims QA process, another random sample was taken and scored. The new system demonstrated a significant improvement in quality of claims submitted with a measured score of 79 percent.

The tangible results of this QA program are greater veteran satisfaction and generally higher ratings. Other benefits noted: veterans are assisted in a more professional, timely manner. Unsubstantiated claims are weeded out early in the process. VA receives substantially completed claims. VA ratings are generally issued in less than 100 days, thus helping the Veterans Benefits Administration (VBA) meet its timeliness goals. Fewer appeals are required. Training needs are identified and addressed, resulting in better trained service officers. The ability to track and demonstrate service officers' proficiency enhances partnerships with veterans and VA. Because the system tracks the tax-free VA compensation payments flowing into the state economy, the information has helped to justify additional state funding of veteran programs. WDVA also believes the program enhances Washington's national reputation for care of veterans and their families.

I.6.A Findings

I.6.A.a Claims Process

The claims process is extremely complex and often not understood by veterans, some of the veterans service representatives, and by many VA employees. Many studies have been completed on timeliness of claims processing, included the ones noted in this report, yet, the delays continue and the frustrations mount for all involved in the process of filing and adjudicating claims and appeals. Most claims filed with the VA are not well documented. Well-documented claims will improve the timeliness of the claims process by reducing the need for development. VA should educate veterans, veterans service representatives, and VA employees about the necessity of filing well-documented claims. In addition, reducing the period of time VA will wait for a response from veterans and medical facilities from 60 days to 30 days will allow VA to improve the timeliness of the claims process because it allows VA to make a decision after the 30-day wait period has expired or would allow VA to follow up after 30 days, rather than 60 days, on a request for evidence or information, all depending on the evidence needed to process the claim. An extension could be granted upon request.

Another benefit for veterans would be to change the commencement date for the period of payment to the effective date of the award. Presently, payment of benefits may not be made for any period prior to the first day of the calendar month following the month in which the award became effective (38 U.S.C. § 5111 [2006]). For example, in a case where the veteran is retired on July 31, 2007, the effective date of the award, by rating, is August 1, 2007. Present law prohibits payment from the effective date and requires VA to make the award from September 1, 2007, and the first payment will not be received until October 1, 2007. A panel of newly discharged veterans reported to the

Commission that it was often difficult to make ends meet because of the delay in the initial payment of VA compensation benefits.

I.6.A.b Appeals Process

The Social Security Administration (SSA) discusses appeal periods in SSA Publication No. 05-10041: "If you wish to appeal, you must make your request in writing within 60 days from the date you receive our letter. We assume you receive the letter five days after the date on the letter, unless you can show us you received it later."³⁹ Under SSA procedures, if a person appeals a decision, the appeal goes forward to a higher level and the original decision maker does not see the case again.

Appeals processes and procedures have become more time consuming than the initial claims decision process. Improvements to the present appeals process will result in more timely decisions for veterans. One of the key points to make on appeals cases is the need to make a quick decision based upon the evidence of record. The longer appeal cases are pending, the greater the likelihood that new evidence or new claims will be introduced, further complicating and delaying the appeals process.

Recommendation 9.1

Improve claims cycle time by

- **establishing a simplified and expedited process for well-documented claims, using best business practices and maximum feasible use of information technology; and**
- **implementing an expedited process by which the claimant can state that the claim information is complete, and waive the time period (60 days) allowed for further development.**

Congress should mandate and provide appropriate resources to reduce the VA claims backlog by 50 percent within 2 years.

Recommendation 9.2

Change the commencement date for the period of payment to the effective date of the award.

Recommendation 9.3

³⁹ SSA, *Publication No. 05-10041ICN*.

Reduce the appellate workload by focusing on improved accuracy in the initial decision-making process, enhance the appeals process by ensuring adequate resources to dispose of existing workload on a timely basis, and deploy technology for transferring electronic records between field offices and the Board of Veterans Appeals.

II Duty to Assist

II.1 Issue

After the *Morton* decision in 1999, Congress reaffirmed the long-standing principle that the Secretary of Veterans Affairs has an obligation to assist veterans in filing and prosecuting their claims (*Morton v. West*, 12 Vet. App. 477 [1999], *opinion withdrawn*, 14 Vet. App. 174 [2000]). VA has a statutory duty to inform the veteran about what is necessary to substantiate his or her claim and to assist the veteran in obtaining the necessary substantiating evidence for the claim.

The Commission investigated whether the current duty to assist laws are appropriate or if veterans, their legal representatives, or both should be responsible for developing supporting evidence from private sources for their own claims. The Commission also studied how VA's duty to assist affects departmental resources, claims backlog, and remand rates, as well as whether VA should clarify what is meant by "sufficient evidence."

In 38 U.S.C. § 5103A [a][1] [2006] the Secretary of Veterans Affairs is required to make reasonable efforts to assist a claimant in obtaining evidence necessary to substantiate a claim for a benefit under a law administered by the Secretary." However, the Secretary "is not required to provide assistance to a claimant under this section if no reasonable possibility exists that such assistance would aid in substantiating the claim" (38 U.S.C. § 5103A [a][2] [2006]). The Secretary can "defer providing assistance...pending the submission, by the claimant, of essential information missing from the claimant's application" (38 U.S.C. § 5103A [a][3] [2006]).

In regards to the Secretary assisting a veteran in obtaining records, the Secretary "shall make reasonable efforts to obtain relevant records (including private records) that the claimant adequately identifies to the Secretary and authorizes the Secretary to obtain" (38 U.S.C. § 5103A [b][1] [2006]). If the Secretary has difficulties in obtaining relevant records, the Secretary "shall notify the claimant that the Secretary is unable to obtain records with respect to the claim" (38

U.S.C. § 5103A [b][2] [2006]). The Secretary currently has the responsibility to aid in obtaining records for compensation claims including “the claimant’s service medical records... [and] other relevant records pertaining to the claimant’s active military...service” (38 U.S.C. § 5103A [c][1] [2006]).

In their 1956 report to the President, the Bradley Commission did not discuss the duty to assist, focusing on the disability ratings system and the philosophy involved in compensation for service-connected disabilities related to military service.

VCAC recommended that “Congress needs to attend to the concept of “duty to assist,” either by providing specific definitions or codifying the court’s rulings.⁴⁰ In discussing 38 U.S.C. §§ 5106, 5107(a), VCAC said,

Although the first sentence [of section 5107(a)] has been interpreted as imposing an almost open-ended duty to assist on the Secretary to develop evidence for the claimant pertinent to the claim, the statute does not say this at all. It says that the Secretary shall assist the claimant in developing the facts pertinent to the claim. Presumably, if Congress had meant “evidence,” it would have said “evidence.” Logically and legally, evidence and facts are two different things. The facts pertinent to the claim are the issues to be evaluated in the context of the criteria for entitlement; evidence is the material necessary to establish those facts as true. The only specific statutory exception applies to pertinent information (evidence) in the possession of a Federal Department or agency. Thus, a literal reading of the statute requires the Secretary to assist the claimant in identifying the facts that must be established, but the burden of submitting evidence to establish those facts remains with the claimant.⁴¹

VCAC also emphasized the importance of a VA and veterans service organization (VSO) partnership by stating that “VA’s claims-processing system does not make effective, systematic use of the accumulated knowledge and communication base embodied by VSO representatives. ”VCAC suggested that VA regulations concerning VSO representation should be restudied and modified to set out specific roles, responsibilities, and limitations of the representative so that VSO support of the claims process may be maximized as the proposed partnership is formulated. They explained that a fully documented claim presented to VA can be readily decided. In fact, they noted that some regional

⁴⁰ VCAC, *Report*, 6.

⁴¹ *Ibid.*, 190.

offices have agreements with VSOs under which a well-documented claim presented to the regional office will be adjudicated immediately. For VCAC, such agreements demonstrated the mutual benefits of building partnerships between claimants, representatives, and VA.

The Veterans' Claims Adjudication Commission (VCAC) believed that well-informed claimants and their representatives, acting in partnership with VA, are in an excellent position to know whether duty to assist and, indeed, all due process requirements have been followed in adjudicating their claims. By making these judgments a routine part of the claims process, VCAC believed that procedural issues associated with adversarial paternalism could be minimized."⁴²

A July 1999 decision made by the U.S. Court of Appeals for Veterans Claims (CAVC) caused a dramatic transformation in the way VA could assist veterans and dependents develop claims (*Morton v. West*, 12 Vet. App. 477 [2006], *opinion withdrawn*, 14 Vet. App.174 [2006]). This change made the claims process much more legalistic and severely restricted VA's discretion in effectuating development of claims. This change also led to an onslaught of challenges to the court's interpretation of the scope and timing of the VA's "duty to assist" and "well-grounded" claim requirement by VSOs and other veterans' advocates.

After the *Morton* ruling, the VA could not assist the claimant or order medical or psychiatric examinations until the claim was "well-grounded," meaning supported by evidence sufficient to convince a fair and impartial individual that a claim is plausible, or, in the CAVC's parlance, "meritorious on its own or capable of substantiation." The court opined that 38 U.S.C. 5107(a) reflects a statutory policy that implausible claims should not consume the limited resources of VA. *Morton* was extremely significant because it demonstrated (and ultimately transformed) the inextricably intertwined nature of the two doctrines: the veteran's duty to submit a well-grounded claim and VA's duty to assist.

In November 2000, Congress enacted the Veterans Claims Assistance Act of 2000 (VCAA) (Pub. L. No. 106-475, 114 Stat. 2096). The law, commonly referred to as the "duty to assist law" legislatively overturned the ruling in the *Morton* decision. This act would "reaffirm and clarify the duty for the Secretary of Veterans Affairs to assist claimants for benefits under laws administered by the Secretary, and for other purposes. Further, the new statute amended 38 U.S.C. §§ 5102, 5103 and added the new sections 5100 and 5103A, expanding VA's duty to assist claimants in several respects. Specifically, 38 U.S.C. § 5103A (a) imposes on VA a duty to assist a claimant by making reasonable efforts to assist

⁴² *Ibid.*, 204.

him or her in obtaining evidence necessary to substantiate a claim for benefits. Other provisions outline the details of providing such assistance in obtaining information, evidence, and records from government and private sources; of informing the claimant if VA is unable to obtain pertinent evidence; and of providing a medical examination or medical opinion when necessary to resolve the claim. Congress specified in detail the various ways in which the Secretary is to perform his duty to assist regarding provision of diagnostic medical evaluations. Section 5103A (d), which is captioned "Medical Examinations for Compensation Claims," states:

(1) In the case of a claim for disability compensation, the assistance provided by the Secretary under subsection (a) shall include providing a medical examination or obtaining a medical opinion when such an examination or opinion is necessary to make a decision on the claim.

(2) The Secretary shall treat an examination or opinion as being necessary to make a decision on a claim for purposes of paragraph (1) if the evidence of record before the Secretary, taking into consideration all information and lay or medical evidence (including statements of the claimant)

(A) contains competent evidence that the claimant has a current disability, or persistent or recurrent symptoms of disability; and

(B) indicates that the disability or symptoms may be associated with the claimant's active military, naval, or air service; but

(C) does not contain sufficient medical evidence for the Secretary to make a decision on the claim.

In July 2000, the Congressional Budget Office estimated the costs of proposed legislation (H.R. 4864, which later became the Veterans Claims Assistance Act) at \$4 million in 2001 and \$7 million to \$8 million annually thereafter.⁴³

In their 2002 report, GAO found that the Veteran Benefits Administration (VBA) regional offices were not consistent in how they were complying with the VCAA.⁴⁴

GAO noted that the VCAA requires VBA to take four steps when assisting a veteran. VBA must:

1. notify claimants of the information necessary to complete the application,
2. indicate what information not previously provided is needed to prove the claim....,

⁴³ Congressional Budget Office, *Cost Estimate of H.R. 4864*.

⁴⁴ GAO, *VBA's Efforts*, 2.

3. make reasonable efforts to assist claimants in obtaining evidence to substantiate claimants' eligibility for benefits..., and
4. inform claimants when relevant records are unable to be obtained.⁴⁵

GAO found that although VBA had given guidance to the regional offices on how to apply the VCAA, results of accuracy reviews completed in VBA's central office showed that regional offices lacked consistency in compliance with the law.⁴⁶ GAO concluded that VBA had provided guidance to its regional offices on how to implement the VCAA. However, despite the efforts of the VBA central office, results from VBA's accuracy reviews indicate a decrease in rating accuracy due to noncompliance with VCAA requirements.⁴⁷ GAO recommended that if VBA continued to experience significant problems with implementing the VCAA, the Secretary of Veterans Affairs should direct the Under Secretary for Benefits to identify the causes of the VCAA-related errors so that more specific corrective actions may be taken.⁴⁸ VA concurred with the GAO recommendation.

Although the Veterans' Claims Assistance Act (VCAA) has aided the veteran during the claims process, it has substantially added to the workload of VBA. After the passage of the law, "claims must now be developed and evaluated under the expanded procedures required by the VCAA."⁴⁹ Additionally, VBA reported that it has had more case files to review as a result of the VCAA. In FY 2001, "VBA received about 95,000 more claims and produced about 120,000 fewer claims decisions" than in the prior year. In FY 2001, 674,219 claims were received compared to 578,773 from the prior year, and 481,117 claims were completed in FY 2001 compared to 601,451 from FY 2000.⁵⁰ VBA decided to undertake a review of cases that had been dismissed because they were not well grounded per the *Morton* decision's interpretation of the statutes. However, VBA claimed that this larger case load could also be attributed to other factors, such as the "addition of diabetes as a presumptive service-connected disability for veterans who served in Vietnam."⁵¹ In addition to increased workload, there were also increased costs associated with the VCAA as estimated by the Congressional Budget Office. VBA needs to continue to make progress in reducing delays in obtaining evidence, ensuring that it will have enough well-trained staff in the long term, and implementing information systems to help improve claims-processing productivity.⁵²

⁴⁵ Ibid., 4.

⁴⁶ Ibid., 2.

⁴⁷ Ibid., 16.

⁴⁸ Ibid., 16.

⁴⁹ Ibid., 11.

⁵⁰ Ibid., 10.

⁵¹ Ibid., 11.

⁵² Ibid., 14.

In his July 2005 presentation to this Commission, the Under Secretary for Benefits for the Department of Veterans Affairs, discussed the Veterans Claims Assistance Act, stating

one of its central provisions clarified and enhanced VA's "duty to assist" veterans with their disability claims. In my opinion, this was a proper and well-conceived law that addressed a deficient process under which VA had been adjudicating claims. It made our adjudicators absolutely responsible for helping each individual veteran know what to do, what is needed to substantiate his or her claim, how to respond, and what we will do to assist him or her. It is also an example of a law which.... has been inordinately difficult to properly execute.⁵³

The Under Secretary further stated that

as a result of VCAA, and the accelerating influx of claims, Secretary Principi convened the Claims Processing Task Force in May 2001. His charge was to "recommend specific actions that the Secretary (of Veterans Affairs) could initiate, within his own authority, without legislative or judicial relief, to reduce the current veterans' claims backlog while processing claims more rapidly."⁵⁴ The objective of our Task Force (whose chairman later became the Under Secretary) recommendations in October 2001 was to improve the efficiency and effectiveness of VBA claims processing.⁵⁵

In speaking about the workload for disability claims, the Under Secretary stated

the number of disability claims received each year has likewise dramatically increased (578,000 in 2000; 771,000 in 2004; about 800,000 projected by the end of FY 2005). A further very real and complicating factor in our process is the number of disabilities (referred to as "issues") veterans are now presenting in each claim. About a decade or so ago, we had 2.5 issues per claim. Today we are seeing higher numbers of "issues"—in many cases, over 10 issues per claim. Across the country, we have seen as many as 40 to 50 issues per claim.⁵⁶ Through the implementation of the Claims

⁵³ Cooper, *Statement before the Commission*, 2005.

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

⁵⁶ *Ibid.*

Processing Task Force recommendations, I believe VBA has laid the basic groundwork that will work to improve consistency in our claims decisions. As previously mentioned, we have made all regional offices similar, if not identical, in organizational structure, work process, and IT application.⁵⁷

In December 2005, The American Legion testified before the House Committee on Veterans Affairs regarding challenges and opportunities facing VA's disability claims processing in 2006. The American Legion testified that although the VCAA was good in intent, VA failed to fulfill the aim of the legislation. The law was meant to aid veterans by informing them of the evidence and information necessary for VA benefits. The law "is a departure from long-standing adjudication policies and procedures, which did not adequately inform and assist individuals with their claims."⁵⁸

II.2 Findings

The goal for the processing of veterans' claims for disability compensation benefits is to have all the evidence necessary to grant the claim at the earliest possible opportunity, ideally at the time the claim is presented to the VA. Whenever a claim is presented to the VA that is not complete, development required to complete the claim delays adjudication.

The Benefits Delivery at Discharge (BDD) program is a good example of meeting the needs of veterans. All the evidence is on record to allow VA to adjudicate the claim before the service member is discharged from active duty. If the service medical records are not sufficient to adjudicate the claim, an examination is conducted and a decision is rendered, all prior to the discharge of the service member from active duty.

Whenever duty to assist becomes a factor in the processing of a claim, the adjudication of the claim must be delayed until legal and procedural requirements are met. VA is, and should be, responsible for notifying a veteran of the evidence necessary to successfully prosecute his or her claim. Reasonable time limits for submitting evidence are necessary, but the current arbitrary allowance of 60 days in every case may not be warranted. Revisiting the intent of Congress as to who should be responsible for obtaining evidence, VA or the veteran, may allow for an opportunity to improve execution of the duty to assist principle and allow for faster claims processing.

⁵⁷ Ibid.

⁵⁸ Mooney, *Challenges and Opportunities*, 2005.

During site visits, the Commission received numerous complaints that the duty to assist letters were not easily understood by veterans, were too “legalistic,” and were too long. Complaints were also received that incomplete letters were mailed to claimants and that additional original development was done when a new issue was added to the claim. The claims process should be examined by all stakeholders with the focus on the quality and timeliness of the development process. VA, the Veterans Claims Adjudication Commission, GAO, and the American Legion, all cited above, have recognized the need to improve the duty to assist requirement. Reviewing the language in development letters to make them easier to understand, both by VA employees and the veteran, and reviewing who is responsible for obtaining which types of evidence (VA or the veteran) would improve the current duty to assist process.

Recommendation 9.4

VA should review the current duty to assist process and develop policy, procedures, and communications that ensure they are efficient and effective from the perspective of the veteran. VA should consider amending Veterans Claims Assistance Act letters by including all claim-specific information to be shown on the first page and all other legal requirements would be reflected, either on a separate form or on subsequent pages. In particular, VA should use plain language in stating how the claimant can request an early decision in his or her case.

Recommendation 9.5

VBA regional office staff must receive adequate education and training. Quality reviews should be performed to ensure these frontline workers are well versed to rate claims. Adequate resources must be appropriated to hire and train these workers to achieve a manageable claims backlog.

III Delayed Payments

An obstacle to the financial well-being of veterans and an effective transition from the military to civilian life is the current statutory requirement that disability compensation payments cannot be paid from the effective date of entitlement, but rather must be delayed until the first day of the second month after the payments are entitled. This requirement was enacted as a budget-saving provision in the Omnibus Budget Reconciliation Act of 1982 (Public Law 97-253, § 401, 96 Stat. 763, 801). It applies even to individuals filing a claim within 1 year

of date of entitlement or date of discharge whose entitlement date is the day after the date of discharge. While this restriction might seem reasonable from the standpoint of reducing costs, it means that service members do not receive any disability benefits for up to two months after discharge. For example, a veteran discharged on August 2, 2006, could not be paid disability benefits for the partial month of August and could not be paid September benefits until October 1. Before this statutory change, the veteran would have received disability benefits from the effective date of August 3. Because veterans—especially those who are unable to work—still have to provide for themselves and their families, the Commission recommends that this statutory requirement be changed.

IV Program Operations Comparison

The Commission was required to evaluate and assess comparable disability benefits provided to individuals by the Federal Government, State governments, and the private sector. The Commission relied upon a study conducted by GAO and requested a comparison of other programs by CNAC.

IV.1 GAO Highlights

In April 2006, GAO published “Disability Benefits: Benefits Amounts for Military Personnel and Civilian Public Safety Officers Vary by Program Provisions and Individual Circumstances.” This report compared the service-connected disability benefits provided to military personnel with the benefits provided for line of duty injuries to civilian public safety officers at the Federal, State, and local level. The report focused on the benefits provided for three main categories of disability: (1) temporary disability, (2) permanent partial disability, and (3) permanent total disability. There were seven main areas of consideration: (1) line of duty injuries, (2) continuation of pay, (3) temporary disability retirement benefits, (4) permanent partial benefits, (5) return to work, (6) inability to work, and (7) total disability.

After conducting their analysis, GAO concluded that a general observation cannot be made concerning which governmental body consistently provides more compensation. Instead, the GAO report recommends observing this issue through a different prism. Their analysis indicates that the variation in benefit packages is dependent on a program’s specific provisions and the individual circumstances of the service member. Therefore, there are cases where the benefits provided to a service member are greater and vice versa. For example, if an individual is unable to work due to a line of duty injury or illness, VA compensation payments for veterans are based on the disability rating, regardless of salary level. In contrast, compensation payments for selected civilian public safety officers are based on salary level, regardless of disability. As

a result, veterans with more severe injuries and lower wages will be compensated at a higher rate by VA. However, other veterans who have less severe injuries and higher wages will be compensated lower by VA.

GAO found that in situations pertaining to issue over line of duty, continuation of pay, and temporary disability retirement, service members receive more compensation. All programs reviewed by the GAO provide benefits to replace a portion of lost wages for individuals in the line of duty up until the time the injury is determined to be permanent and/or the individual can return to duty. However, service members are treated differently than public service officers. GAO compared the program provisions that govern service member line of duty injury to those that govern most civilian public service officers and found that injured service members are more likely to qualify as line of duty injured. This is because service members are on duty 24 hours a day, 7 days a week. In addition, continuations of pay provisions for service members are generally more flexible. Finally, the starkest difference between service members and public safety officers is the fact that service members are eligible to receive access to temporary disability retirement benefits.

IV.2 CNAC Highlights

CNAC was tasked to compare VA's disability compensation program with other federal disability compensation programs. This was done to develop recommendations that could be made by the Commission to VA to improve its operations. CNAC's analysis of VA's program operations can be found in Chapter 6, "Compensation, Survey Results, and Selected Topics," of this report.

CNAC compared the VA system to Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Federal Employees' Workers' Compensation Act, Federal Employee Retirement System, Civil Service Retirement System, and the Disability Evaluation System. To complete its comparative analysis, CNAC completed two tasks. First, it identified the major criticism of operations in VA's disability program. This included the following: (1) basic performance measures, (2) physical consolidation of offices, (3) balancing quality and quantity in employee performances, (4) training, (5) staff turnover, and (6) claimant representation. Second, it determined whether VA could address some of the criticisms using "lessons" from other federal disability compensation programs.

In respect to the criticism concerning basic performance measures, CNAC looked at three variables: consistency, accuracy, and timeliness. CNAC discovered that VA does not have a current measure of consistency. However, they recognized that none of the other federal disability compensation programs

have applied the necessary elements for measuring consistency. CNAC determined that the recommendations made by GAO concerning consistency were not in place in any federal program. GAO recommended including the following components in assessing consistency: (1) the use of multivariate regression analysis examining disability decisions along with controlling factors to determine whether the decisions are consistent, and (2) an in-depth independent review of a statistically valid group of case files to determine what factors may contribute to inconsistencies. CNAC recommended that one way to reduce inconsistency in disability programs would be to implement physical consolidation. At the moment, VA and SSA already have taken some steps to consolidate elements of the disability claims processing, but CNAC found that more should be done.

In respect to the criticism concerning basic performance measures, CNAC discovered that VA's accuracy rate in 2006 was 88 percent, which CNAC compared to SSDI (96 percent). CNAC concluded that this discrepancy is most likely the result of differences between the programs and their requirements for processing a claim. For example, VA has to rate the severity of a disability, which creates more potential for error than the yes-or-no disability decision required for SSDI. To improve the accuracy rate, CNAC recommends that VA adopt SSA's focus on the most error-prone cases. The VA's Systematic Technical Accuracy Review (STAR) program would need to be expanded. CNAC believes this would result in a great improvement in accuracy for VA claims processing.

In respect to the criticism concerning basic performance measures, CNAC discovered that compared to other disability program's VA's timeliness performance is poor. The average time for VA to complete a claim in FY 2006 was 177 days, which does not include appeals. In contrast, the average SSDI claim took 88 days in FY 2006, and the Federal Employee Retirement System, Civil Service Retirement System's average is 38 days. CNAC could not determine the exact cause for the poor performance, except that differences exist because of VA's complicated disability decision-making process, staffing shortages, low productivity, or some unknown factors. Also, the differences across programs in the work required to process a claim make it difficult to pin down the cause. CNAC makes note of VA's attempt to fix the problem by utilizing "Tiger Teams" to deal with cases that are designated as high priority at any given time. This program has been successful, but CNAC finds that this is no surprise considering that the "Tiger Teams" are made up of the most experienced staff. This emphasis makes it impossible for VA to replicate due to its staff shortage. One recommendation CNAC made is for VA to study SSA's Quick Disability Determination process. This involves the use of predictive models to identify cases with high probability of being granted benefits and then trying to act on those cases within 20 days.

In respect to the criticism concerning balancing quality and quantity in employee performance, CNAC discovered there exists a perception that VA emphasizes quantity over quality. In a national survey, 80 percent of raters said having enough time to process a claim was one their top three challenges. They were also asked to rate the availability of time to decide a claim, 54 percent of raters said availability of time was fair or poor. It can be argued that this creates incentives for RVSRs to make decisions that are not always fully backed by evidence, which leads to more appeals, and remands, and increases backlogs in the system. CNAC's interviews with VA staff and review of congressional testimony convinced it that there are well-defined standards for both quantity and quality of employee performance. CNAC also found that VA is not the only disability program facing issues over balance. SSA disability evaluations have indicated that employees also felt the emphasis on productivity had a negative impact of accuracy.

In respect to training, CNAC concluded that the criticism is unfounded. In relation to other disability programs, VA's level of standardization of training is unmatched. In addition, CNAC discovered that the other disability programs do not have formal evaluations of their training. CNAC believes that the VA's training difficulties are made exponentially worse because staff feel a need for more training and that training seems to be sacrificed to meet work quotas. This emphasis has encouraged a high staff turnover at VA. The quality of claims is lessened since inexperienced individuals are taking over for experienced raters. Surprisingly, CNAC found that VA's attrition rate was 15 percent for FY 2000, which was lower than the federal average of 17 percent. But, CNAC concluded that comparisons with other Federal agencies are irrelevant. The complicated nature of VA's work demands it spend vast amount of resources training its employees. When an experienced employee leaves, the consequences ripple more across VA than at most other Departments.

In respect to the criticisms concerning claimant representation, CNAC discovered that there is wide variation amongst veteran service organizations concerning the quality of training that accompanies each representative. There are some representatives who are highly qualified while others are not. The reason for the variability is that accreditation of each representative is made by the veterans service organizations. With few exceptions, most federal disability programs do not have involvement in external representation for claimants.

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10

Transition

The Commission examined the policies and processes within the Departments of Defense (DoD), Veterans Affairs (VA), Labor (DOL), Health and Human Services (HHS), and the Social Security Administration (SSA) that affect military separation or retirement. Each of these entities plays a significant role in the readjustment—or “transition”—of veterans and their families to civilian life.

Transition is a complex, complicated time for many service members, especially for those with disabilities. This chapter assesses transition in relation to the roles and functions of the government and the problems and risks encountered by veterans and their families.

I Transition Philosophy

Overall, the Commission is committed to seamless transition as the goal. VA and DoD must support and encourage business practices that include joint ventures, sharing agreements, and integration. If these and other operational processes are kept at the forefront of the Departments’ operations, then successful transition for the service member could be more readily attainable. Because VA and DoD have separate missions and funding processes, transition policies must be well coordinated to achieve effectiveness and efficiency. Historically, there have been barriers to collaboration between VA and DoD because the two organizations lack a stable business environment, a standard process for submitting proposals, local incentives for collaboration, and a process to address agreement risk.¹ These barriers should be fully addressed with a strong emphasis on joint management by VA and DoD.

The sharing of health care information and resources by DoD and VA would significantly benefit veterans in the transition process. This practice must encompass general and specialized care, education and training, research, and administration. VA and DoD should coordinate local and national health services through direct sharing agreements, Tricare contracts, joint contracts for

¹ President’s Task Force, *Final Report*, 46.

pharmaceuticals and medical and surgical supplies, information technology collaboration, and joint facility management.² Existing and future joint contracts should take advantage of both Departments' economies of scale and increase their purchasing power.

In FY 2006, each Department made available \$9 million for resource sharing³ (from their combined \$50 billion health care budgets.) The Commission witnessed several of these initiatives:

- In Florida, the Army Community-Based Health Care Organization allows injured or ill National Guardsmen and reservists still on active duty to receive treatment at VA or private-sector facilities closer to home.
- In Georgia, VA rehabilitation services are provided for active duty members.
- In Illinois, the Great Lakes Federal Healthcare Facility is managed by VA and the Navy.
- In Texas, resources were provided for a new primary care clinic, and in San Antonio, the Intrepid Rehabilitation Center was funded by the private sector and requires that VA and DoD jointly fund its future operations.

Local facility managers view such local approaches as the best way to get things done and want the authority to negotiate memoranda of understanding, sharing agreements, and joint ventures as independently as possible. These ventures maximize resource utilization, increase market penetration, and enhance buying power for all entities involved.

The VA/DoD Joint Executive Council (JEC) Strategic Plan and its supporting activities and task forces should develop policies which require streamlining and integrating transition services to achieve success in the following areas:

- Coordination
- Case management
- Transition Assistance Program (TAP)
- Benefits Delivery at Discharge (BDD) and separation physicals
- Information technology and record management
- Family support services
- Military severely injured
- Health care

² Task Force on Returning, *Report*, 24.

³ VA/DoD, *2006 Annual Report*, 30.

If not properly addressed, service members and their families are at risk for unsuccessful transitions. Today's veterans, who have to leave Tricare, submit a claim for disability compensation, apply for other benefits, enroll at a VA hospital, and have a compensation and pension (C&P) examination, find that transition is not seamless. The challenges faced by some service members who do not successfully transition from military to civilian life could result in periods of homelessness, incarceration, unemployment, divorce, and poor mental health.

I.1 Transition Risk Issues

In spite of the fact that some of the best and the brightest serve in the Armed Forces of the United States, military separation or retirement is not without its pitfalls. Engaging in such a major life change can be difficult for the most seasoned service member, to say nothing of a disabled veteran. Recent recruits are more likely to have high school diplomas, to have scored in the 50th percentile or higher of standardized aptitude tests, to come from above-average income neighborhoods,⁴ and later to be recruited by Fortune 500 companies, educators, and the federal government. Even so, there are still veterans who face the complications of improper housing, lack of support, and the inability to access information.

I.1.A Homelessness

VA offers an integrated network of services for homeless veterans. The goal of the Housing and Urban Development (HUD) Veteran Resource Center is to provide veterans and their family members with information on HUD's community-based programs and services, including reintegration and vouchers at transition. This information should be included in the transition assistance program briefings.

I.1.B Unemployment

Some veterans have faced unemployment and underemployment. U.S. unemployment rates routinely fluctuate, and veterans, like everyone else, are subject to economic vacillations. However, "the unemployment rate for all Americans is now [in 2006] 4.6 percent. Veterans are doing even better—their unemployment rate is 3.5 percent."⁵ Additionally, the U.S. Office of Personnel Management reported that veterans hold 25 percent of all federal jobs.⁶ Yet, there are incidences of non-compliance with veterans' preference enforcement in hiring and contracting and with civilian requirements for certification and licensure.

⁴ Beland and Gilroy, *All-Volunteer Military*, A21.

⁵ Craig, *Strong Employment Numbers*.

⁶ Office of Personnel Management, *Veterans Continue*.

I.1.C Mental Illness

Major contributing factors to adjustment problems for combat veterans are posttraumatic stress disorder (PTSD), depression, anxiety, and substance abuse, any of which can lead to suicide. According to post-deployment health assessments, 15 to 17 percent of Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans have screened positive for PTSD, 20 percent for depression, and 20–25 percent for alcohol abuse.⁷ Chronic and delayed PTSD are especially difficult to treat and manage, placing an even greater demand for resources on the VA health care system, especially when traumatic brain injury (TBI) is also involved.

Several epidemiological studies suggest that women are more likely to develop PTSD than males, even though males are more likely to be exposed to traumatic events.⁸ IOM noted that combat exposure was an even greater precipitant to the development of PTSD and that “women veterans were nine times more likely to develop PTSD if they had a history of MSA [military sexual assault].”⁹ With an increasing number of women serving in Iraq and Afghanistan, women face growing chances of being exposed to combat, witnessing death, and being assaulted or wounded, all of which can lead to life-long aftereffects. Research studies, diagnostic tools, and intervention techniques, which are predominantly designed for a male cohort, need to be redesigned to suit the experiences of women veterans.

PTSD compensation rates among all service-connected disabled veterans grew by 79.5 percent between FY 1999 and 2004. While veterans being compensated for PTSD represent only 8.7 percent of all compensation recipients, they receive 20.5 percent of all compensation payments.¹⁰ In 2006, VA treated 345,713 veterans with PTSD (including 34,000 OIF/OEF era veterans¹¹), an increase of 27,099 people over 2005. As of FY 2005, 244,876 veterans were receiving compensation for PTSD.¹²

If left unaddressed, mental disorders—especially PTSD—can have a grave impact on earnings and quality of life and may result in premature death because of risk-taking behavior, violence, overdosing, and suicide. In 1999, IOM noted that increased mortality rates among Gulf War veterans attributed to accidents

⁷ Hoge, *Mental Health, PTSD*.

⁸ Foa, Keane, and Friedman, *Effective Treatments for PTSD*, 20.

⁹ Institute of Medicine, *Posttraumatic Stress Disorder*, 39-41.

¹⁰ VA, *Review of State Variances*, vii.

¹¹ *DoD/VA Cooperation and Collaboration*, statement of Gordon H. Mansfield.

¹² Veterans Benefits Administration, *Fiscal Year 2005*, 32.

were similar to those of Vietnam veterans.¹³ In response to reported incidents of suicide, VA instituted a comprehensive suicide prevention program and a hotline in conjunction with the National Suicide Prevention Hotline (1-800-273-TALK) in July 2007. DoD has a risk-reduction committee and Military OneSource, and the services have suicide prevention programs.

II Coordination

To minimize the risks associated with transition, VA, DoD, HHS, SSA, DOL, and other entities such as the veterans service organizations (VSOs) and state agencies have joined forces to assist with military separation and retirement. Yet the primary responsibility for service member transition falls on DoD and VA. There have been guidelines in place for VA/DoD health care resource sharing since July 1979 (38 U.S.C. § 8111).¹⁴ Recently, greater emphasis has been placed on sharing and transition since the inception of the Global War on Terror and the advent of the Joint Executive Council.

In 2003, Public Law 108-138 required that VA and DoD create a Joint Executive Council (JEC) to enhance coordination and resource sharing between the two organizations. JEC is co-chaired by the VA Deputy Secretary and the DoD Under Secretary for Personnel and Readiness. Reporting to the JEC are the Health Executive Council (HEC) and the Benefits Executive Council (BEC) that were created to ensure that resources and expertise are specifically directed to those crucial areas.¹⁵ “The HEC is responsible for implementing a coordinated health care resource sharing program. The BEC is responsible for examining ways to expand and improve benefits information sharing, refining the process for records retrieval, and identifying procedures to improve the benefits claims process.”¹⁶ Seamless transition has been defined by the JEC as “an approach to health care and benefits delivery whose goal is to ensure continuity of services through the coordination of benefits, with the intended result of improving the understanding of, and access to, the full continuum of benefits and services available to service members and veterans through each stage of life.”¹⁷ Each year the JEC issues an annual report outlining its activities regarding seamless transition, health care, operations, joint readiness, information technology interoperability, and joint ventures and sharing agreements.

The congressional mandate for the JEC did not include other agencies, such as DOL and the Social Security Administration (SSA), that are major players in

¹³ Institute of Medicine, *Gulf War Veterans*.

¹⁴ VA/DoD, *2005 Annual Report*, B-1.

¹⁵ VA Office of Policy, *VA/DoD Collaboration*, 1.

¹⁶ *DoD/VA Cooperation and Collaboration*, Statement of David S.C. Chu.

¹⁷ VA/DoD, *2005 Annual Report*, 2.

transition assistance programs and in seamless transition. Including DOL and SSA in the JEC in some capacity may improve coordination even further.

In reviewing the *VA/DoD JEC Strategic Plan Fiscal Years 2007–2009*, the Commission questions the detail of planning efforts. Implementation plans do not include milestones, funding requirements, and assignment of responsibilities. According to VA, “the JEC *Annual Report* includes major accomplishments as they relate to the Joint Strategic Plan” and is “not intended to be a detailed operational guide.”¹⁸ However, according to GAO, a more detailed plan with a responsible lead agent is needed by the Departments.

To further address transition, VA created an Office of Seamless Transition with a director who reports to the Under Secretary for Health and a staff of coordinators and liaisons to work internally with the Veterans Benefits Administration (VBA) and externally with DoD’s active duty, National Guard, and Reserves. There is also no counterpart to this office within DoD. Seamless transition in DoD is the responsibility of the Deputy Director of Deployment Health Support Directorate as a collateral duty who in turn coordinates with Health Affairs and Personnel and Readiness.

Recommendation 10.1

VA and DoD should enhance the Joint Executive Council’s strategic plan by including specific milestones and designating an official to be responsible for ensuring that the milestones are reached.

Recommendation 10.2

The Department of Labor and the Social Security Administration should be included in the Joint Executive Council to improve the transition process.

III Case Management

For military transition to be seamless, the handoff between DoD and VA should not be adversarial, confusing, or challenging. Severely injured service members report being overwhelmed by the number of contacts and business cards collected from those who want to help. No single point of contact coordinates all of their benefits and care.

¹⁸ VBA, *Technical Review*, 2.

An independent review group found several problems with the DoD outpatient case management process. These included an ill-defined process; differing treatment plans and medications; improper staff-to-patient ratios; lack of centralized management of staff; lack of standards, qualifications, and training of staff; unqualified contractors; and inconsistencies across the services.¹⁹ The Task Force on Returning Global War on Terror Heroes found that “there are no formal interagency agreements between DoD and VA to transfer case management responsibilities across the military services and VA” and recommended that a system of comanagement be developed.²⁰ The President’s Commission on Care for America’s Returning Wounded Warriors recommended that there be a recovery coordinator who acts as “the patient and family’s single point of contact, who makes sure each service member receives the care specified for them in the [recovery] plan when they need it, and that no one gets lost in the system.”²¹

The establishment of a lead-agent case manager by VA and DoD would minimize confusion and alleviate the stress on transitioning service members and their families in tracking information and accessing services over the long term.

Recommendation 10.3

VA and DoD should jointly create an intensive case management program for severely disabled veterans with an identifiable lead agent.

IV Transition Assistance Programs

The Transition Assistance Program (TAP) and the Disabled TAP (DTAP) are the employment and benefits briefings conducted at military installations for service members in preparation for leaving the armed services. These briefings are conducted 90 to 180 days before discharge. TAP and DTAP are opportunities to address transition issues and to give veterans and their families the information, support, and assistance they will need to successfully readjust to civilian life.

According to the report of the Congressional Commission on Servicemembers and Veterans Transition Assistance, “TAP is offered at a critical juncture of the servicemembers’ life at a time when he or she is getting ready to move from DoD jurisdiction to the jurisdiction of other departments and agencies, such as VA,

¹⁹ Independent Review Group, *Rebuilding the Trust*, 11–15.

²⁰ Task Force on Returning, *Report*, 20.

²¹ President’s Commission, *Returning Wounded Warriors*, 4.

DOL, and the Small Business Administration.”²² Public Law 101-510 mandates that DoD offer TAP, and DoD Instruction 1332.36 provides guidance to the services through their community services or family support centers. The Marine Corps is the only Service to mandate attendance at the TAP classes. TAP is delivered in partnership with DOL and VA. DOL, under its Veterans' Employment and Training Services, has a lead role in the TAP process. DOL has operated the ReaLifelines program for disabled veterans since 2004, and staffs offices at military treatment facilities and within the Military Severely Injured Center.

DTAP is provided to those who intend to file a claim for a service-connected disability or an illness or injury that was aggravated by service. DTAP can begin the BDD process. At that time, applications for compensation, vocational rehabilitation and employment, and health care can be made prior to the service member's discharge. Additionally, Social Security Disability Insurance (SSDI) can be awarded to severely injured service members even while they are still on active duty.

In FY 2005, 7,500 TAP/DTAP briefings were held for 310,000 service members and their families, including 119,000 National Guard members and reservists.²³ During FY 2005, 144,965 active-duty service members were discharged.²⁴

The Departments are trying to make TAP more accessible to all separating service members, especially National Guard and Reserves, and to their families. There have been issues with mandating TAP/DTAP for all service personnel as DoD does not control all of the human or fiscal resources that support this activity. On September 19, 2006, a new memorandum of understanding was signed by DoD, VA, and DOL to redefine departmental roles and responsibilities for the TAP/DTAP, which should increase class availability. To ensure that TAP is accessible to all separating service members, Congress should mandate class availability and class attendance DoD wide.

Funding for TAP has remained fairly constant for the last decade with no increases for inflation. In FY 1997, the TAP allocation was \$40 million; Table 10.1 shows how those funds were distributed among the services.

²² Congressional Commission, *Report*, 38.

²³ VA/DoD, *2005 Annual Report*, 4.

²⁴ Associated Press, "Numbers Leaving the Military."

Table 10.1 TAP Allocations for FY 2007

SERVICE	PERCENTAGE OF TOTAL ALLOCATION (%)	DOLLARS (thousands)
Army	36	13,287
Navy	28	10,220
Marine Corps	11	4,000
Air Force	25	8,943
Total	100	36,450

SOURCE: Applegate, "TAP funding."

Adequate funding, including increases for inflation, should be provided for the TAP and DTAP programs.

Recommendation 10.4

To facilitate seamless transition, Congress should adequately fund and mandate the Transition Assistance Program throughout the military to ensure that all service members are knowledgeable about benefits before leaving the service.

V Benefits Delivery at Discharge and Separation

To expedite the claims process, VA and DoD jointly developed and implemented the Cooperative Separation Process/Examination at BDD sites. The purpose of BDD is to allow service members to file VA claims prior to separation. This initiative grew out of concerns for the growing backlog at the VA regional offices as the number of pending claims increased. Veterans who do not file a claim through BDD must have their claims processed at a regional office, which adds to their wait time for a decision because of the backlog. To assist in this process, DoD is required to transmit pertinent medical information to VA.²⁵

BDD is offered at 140 military facilities. VA processes those claims at two centralized locations: Salt Lake City, Utah, and Winston-Salem, North Carolina. For FY 2006, 40,600 transitioning service members went through the BDD process to file original compensation claims.²⁶

²⁵ VA/DoD, *2005 Annual Report*, 4.

²⁶ VA, *2006 Annual Performance*, 1–2.

For service members to be eligible for BDD, they must have an established date of discharge and be within 180 days of discharge. Those on medical hold or on the temporarily disabled retired list are often precluded from entering BDD because they do not have established discharge dates. An authenticated electronic DD 214²⁷ sent by DoD to VA could also expedite this process and assist in getting service members enrolled in VA for medical care. Additionally, severely injured service members who appeared before the Commission reported being denied access to VA health care because they were still on active duty.

There have been mixed reactions to the BDD process. During site visits, the Commission heard conflicting reports on BDD. For example, in Florida, there were concerns with sending cases to the North Carolina regional office for ratings, which might increase confusion and impede follow-up. At the Boston regional office, they were relieved to not have the added workload. Additionally, veterans at town hall meetings and on panels reported varied experiences with BDD and inconsistencies in assistance. Most veterans were satisfied with the expeditious turn around in receiving VA awards; however, others who had been found unfit for duty and separated from the service, reported that they were denied VA compensation and attributed it to the BDD process being too rushed.

There are several other issues aside from BDD that influence benefits at separation. First, DoD does not currently conduct separation examinations on every service member leaving the military, but only for those who intend to file a claim for VA disability benefits. A separation examination would establish a baseline for medical conditions, so that if, and when, a veteran chooses to file a claim, information will be available on their health status at discharge. A separation examination could also be useful in reducing the VA claims backlog.

Additionally, as a result of the cost containment measures in the Omnibus Budget Reconciliation Act of 1982 (Public Law 97-253, § 401, 96 Stat. 763, 801, now 38 U.S.C. § 5111), VA is prohibited from authorizing disability compensation payments until the first day of the second month after the award is granted. Therefore, payments are delayed. This law also applies to veterans who file a claim within 1 year of discharge and whose entitlement date is the day after the date of discharge. The result is that service members do not receive any disability benefits for up to 2 months after discharge. For example, a veteran discharged on August 2, 2006, could not be paid disability benefits for the partial month of August and could not be paid September benefits until October 1. When severely injured service members testified before the Commission in January 2006, this was a primary concern. Before the 1982 statutory change, the

²⁷ Military discharge papers.

veteran would have received payment from the effective date, which in this example would be August 3.

Post-military employment is another separation issue. Veterans sometimes have difficulty translating their military occupational specialty (MOS) to civilian certifications and licenses, such as when an Army medic applies for a job as a civilian emergency medical technician. In response, DoD created a Web site to provide access to the Verification of Military Experience and Training VMET document, which “provides descriptive summaries of the service members’ military work experience, training history, and language proficiencies” in addition to recommended college credits equivalent to military training and experiences.²⁸ The Army created the Credentialing Opportunities On-Line (COOL) that “helps soldiers find civilian credentialing programs related to their MOS.”²⁹ (Navy COOL followed in 2006.)

The Task Force on Returning Global War on Terror Heroes made several additional recommendations regarding improving employment awareness at job fairs, improving certification and credentialing opportunities for transitioning service members, and spreading awareness regarding the Uniformed Services Employment and Reemployment Rights Act.³⁰ DoD, VA, and DOL should take additional steps to expand MOS awareness in the private sector and offer employment counseling to assist transitioning service members in documenting and describing their military experiences as assets to potential employers.

Recommendation 10.5

Benefits Delivery at Discharge should be available to all disabled separating service members (to include National Guard, Reserve, and medical hold patients).

Recommendation 10.6

DoD should mandate that separation examinations be performed on all service members.

Recommendation 10.7

Disability payments should be paid from the date of claim.

²⁸ *DoD/VA Cooperation and Collaboration*, 15.

²⁹ *Ibid*, 16.

³⁰ Task Force on Returning, *Report*, 54–57.

Recommendation 10.8

DoD should expand existing programs that translate military occupational skills, experience, and certification to civilian employment.

Recommendation 10.9

DoD should provide an authenticated electronic DD 214 to VA.

VI Information Technology and Record Management

Information technology (IT) interoperability is the cornerstone for successful cooperation between the Departments and a truly seamless transition for service members. Seamless transition is envisioned as a system that would “flow easily across all components of care, geographic sites, and discrete patient care incidents while protecting privacy and confidentiality...and would provide VA and DoD with insights about diseases or illnesses that could result from exposure to occupational hazards during military service and assist in epidemiological research.”³¹ Although most attention has focused on medical systems, electronic military personnel systems are also important to improving transition.

To achieve this level of functionality, the JEC developed a Joint Electronic Health Records Interoperability (JEHRI) plan that incorporates a series of separate initiatives to connect DoD's and VA's electronic health information systems. (DoD's system is called AHLTA and VA's is called the Veterans Health Information Systems and Technology Architecture, or VistA.) This 5-year plan is overseen by the Health Executive Council. The JEHRI plan includes the development of the Federal Health Information Exchange (FHIE), which is a one-way transfer of military health data from DoD to VA's Computerized Patient Record System. Since 2002, 3.6 million patient records have been transferred, and 2 million of these veterans received care from VA. “The Compensation and Pension Records Initiative (CAPRI) electronic health records, including FHIE categories, are available to VBA employees at 57 regional offices. Access to CAPRI helped accelerate the adjudication of compensation and pension benefit claims.”³²

Using FHIE, DoD was able to transmit information to VA on its patients being treated in DoD facilities under local sharing agreements. As of September 2006,

³¹ President's Task Force, *Final Report*, 7.

³² VA/DoD, *2005 Annual Report*, 12.

1.8 million data transmissions have taken place.³³ Following the success of FHIE and building upon it, VA and DoD developed the Bidirectional Health Information Exchange (BHIE), which expanded access to patient information including pharmacy data, pathology and surgical reports, laboratory, radiology (no images), and other test results and allergy information. As of February 2006, VA could access data from nine military treatment facilities (Madigan, Beaumont, Eisenhower, Great Lakes, San Diego, Nellis, Walter Reed, Dewitt, Bethesda, and O'Callaghan) and these facilities could access VA records. DoD added the Pre- and Post-Deployment Health Assessments (PPDHA) for transitioning service members and demobilized reservists and National Guardsmen to the FHIE system. As of September 2006, over 1.4 million PPDHAs on 604,000 individuals have been transferred. DoD completed a historical data extraction and will continue to transfer these assessments on a weekly basis to VA once a referral is recorded.³⁴ Other military personnel data sharing plans are in process.³⁵

Continued expansion of bidirectional capabilities known as the Clinical Data Repository/Health Data Repository will be a bridge between the new AHLTA and VistA. Additionally, laboratory data sharing and interoperability software will continue to leverage the Departments' abilities to work together and create standardization across systems that ensure patient safety. Despite these efforts, the AHLTA and VistA platforms are not currently compatible. AHLTA may provide a more modern platform than VistA, but significant functions in the older VA system are not available to DoD users. For example, inpatient discharge summaries and digital images from CT scans, MRIs, and x rays are part of VistA, but these records and images are not yet available in AHLTA. Therefore, DoD cannot easily transfer these types of documents to VA upon a service member's discharge without paper copies first being scanned. VA and DoD plan to share patient encounters, clinical notes, problem lists, and theater data no later than December 2007.³⁶

The JEC FY 2006 *Annual Report* states, "VA and DoD will utilize interoperable enterprise architectures and data management strategies to support timely and accurate delivery of benefits and services. The emphasis will be on working together to store, manage, and share data and streamline applications and procedures to make access to services and benefits easier, faster, and more secure."³⁷ However, greater progress should have been made, and the 5-year strategic plan does not meet the demands of the current level of combat operations and casualties.

³³ Ibid., 17.

³⁴ Ibid.

³⁵ Ibid., 22.

³⁶ Freedman, *VA/DoD Electronic Health Information Sharing*.

³⁷ VA/DoD, *2006 Annual Report*, A-21.

During the last decade, GAO has monitored the IT efforts of VA and DoD. GAO found that the Departments have made progress, but there is still a great deal that needs to be done in the short term and the long term. VA has achieved IT integration, but DoD still faces challenges standardizing the services' health information systems. VA and DoD have not yet properly developed an overall strategy to guide their various efforts towards achieving a comprehensive seamless exchange of health information. GAO has recommended that there be a detailed project management plan developed to guide efforts and a lead entity identified.³⁸

The Task Force on the Returning Global War on Terror Heroes encouraged the Departments to expand their IT initiatives and enhance electronic health records for OIF/OEF veterans, improve patient tracking between systems, and to track TBI patients, combat veterans, and polytrauma patients. The Task Force also recommended that VA improve its electronic enrollment capabilities and to use DoD's military service information as part of VA's enrollment process.³⁹ The report also calls for VA to improve its IT interoperability with the Department of Health and Human Services (HHS) and Indian Health Service.⁴⁰

The President's Commission on Care for America's Returning Wounded Warriors acknowledged that IT is not the "silver bullet," but recommended that DoD and VA rapidly transfer patient information to support an efficient patient-centered system.⁴¹ Additionally, it advocated the development of a single federal benefits' Web site (*MyeBenefits*) where veterans can locate all necessary information, store personal records, make appointments, and apply for benefits⁴²

On January 24, 2007, VA and DoD announced an agreement to create a joint inpatient electronic health record that will make inpatient medical records instantly accessible to clinicians in both Departments. However, the Departments have not committed to a completion date.

In spite of efforts by VA and DoD to use compatible electronic record systems, the goal is far from realization, and paper records will be in use well into the future. VBA continues to use paper claims folders and has no long-term plan to convert them to electronic records. Many DoD records are also still in a paper format, and need to be transferred to VA. At the St. Louis Records Management Center visited by the Commission, there is a large volume of unidentifiable and unmatched records. These missing documents can have a grievous affect on a

³⁸ Melvin, *VA and DoD*, 2-4.

³⁹ Task Force on Returning, *Report*, 29-36.

⁴⁰ *Ibid.*, 48.

⁴¹ President's Commission, *Returning Wounded Warriors*, 9.

⁴² *Ibid.*, 23.

veteran's ability to document a claim for service connection. A joint VA/DoD task force has been established to address this situation, but resolution can take years.

Recommendation 10.10

VA and DoD should improve electronic information record transfers and address issues of lost, missing, and unassociated paper records.

Recommendation 10.11

VA and DoD should expedite development and implementation of compatible information systems including a detailed project management plan that includes specific milestones and lead agency assignment.

VII Family Support Services

DoD has an array of family assistance programs that include services for families of injured or ill service members to help keep families together. These services include family centers, child care, youth programs, family advocacy, relocation, transition support services, and support during mobilization and deployment (including casualty affairs).⁴³ At an installation's community services or family center, family members can be assisted with job placement, parenting classes, family readiness groups, and reunion and reintegration briefings, especially when a service member has been injured or becomes ill. The Family Advocacy Program intercedes in cases of domestic violence and child abuse.

There are limitations to the DoD programs such as those identified by the President's Commission on Care for America's Returning Wounded Warriors, which focused on the lack of Tricare respite care and aide and personal attendant benefits under the Extended Care Health Option program.⁴⁴

There are further gaps in services when service members leave active duty and transfer to VA. Under title 38 U.S.C., VA has no statutory authority to treat or assist veterans' family members, other than in some very limited capacities and only when the veteran is the identified patient. DoD realizes the importance of family support and can provide significant financial assistance, travel, and housing near military treatment facilities for the families of the severely injured. There are no special VA programs or projects designed for spouses, children, or parents, grandparents, or siblings of disabled veterans. As caregivers, they do not have the travel and per diem benefits available from VA as they do when

⁴³ Under Secretary of Defense, *Military Community*.

⁴⁴ President's Commission, *Returning Wounded Warriors*, 8.

injured service members recuperate while on active duty, nor are they assisted with employment or health care if they need to relocate nearer to a facility that provides the level of care that the veteran requires.

Recommendation 10.12

Congress should authorize and fund VA to establish and provide support services for the families of severely injured veterans similar to those provided by DoD.

VIII Military Severely Injured

With casualties being medevaced from Iraq and Afghanistan with complex and multiple injuries, response needs to be efficient and effective. Body armor, an improved evacuation system, and coagulants are allowing an estimated 90 percent of the troops to survive battle wounds, particularly blast injuries from improvised explosive devices. Serious injuries include amputations, traumatic brain injuries, visual and hearing impairments, burns, other life-threatening conditions, and PTSD. As a result of these traumatic and multiple injuries, DoD created new programs. DoD oversees the Military Severely Injured Center (MSIC), while the services have their own programs: Army Wounded Warrior, Navy Safe Harbor, Marines4Life, and Air Force Palace Heart.

Medical hold patients at Walter Reed Army Medical Center and the National Naval Medical Center are being assigned to specific Army or Marine Corps Wounded Warrior Regiments to better assist and oversee their care. These programs link injured service members and their families to medical care and rehabilitation; education, training and job placement; personal mobility equipment; home, transportation, and workplace accommodations; individual, couple, and family counseling; and financial resources in order to return to duty or to integrate back to their home communities.⁴⁵

It is difficult to evaluate the effectiveness of these services for the severely injured and their families, however, as there is no standard definition of the term “severely injured” and there is no common DoD database capturing service member and family workload or the services provided. It is also difficult to provide VA with a comprehensive status report on these cases for continuing treatment purposes. As a result, there are limited opportunities to identify lessons learned that could be shared within DoD or with VA, or to develop strategic plans that target funding more effectively.

⁴⁵ Military Home Front, *Severely Injured Center*.

Recommendation 10.13

DoD should standardize the definition of the term “severely injured” among the services and with VA, and create a common database of severely disabled service members.

VIII.1 Severely Injured Marines and Sailors Pilot Study

The Assistant Secretary for the Navy, Manpower and Reserve Affairs, authorized the Severely Injured Marines and Sailors (SIMS) Study as a pilot program to determine whether there were gaps in the Navy’s support of injured sailors and Marines and their families, and whether changes to internal and external policies were warranted. “The purpose of SIMS is to accelerate the retirement dates of the severely injured Marines and sailors who are unlikely to return to duty within 12 months of injury and [to] enhance the compensation and benefits they are entitled to receive in order to reduce economic stressors on the family, to reduce uncertainty and fear about the future, and to increase the focus on getting better.”⁴⁶ The pilot program included 25 severely injured individuals and identified the complexities and confusion they faced in navigating through the DoD, VA, DOL, and SSA benefit systems. The solution was to improve coordination between these agencies by convening an interagency working group that was composed of over 50 agency representatives.⁴⁷

Among the SIMS study findings and recommendations were the following:

- Develop a comprehensive patient tracking system across agencies.
- Implement a master case management component that coordinates all activities.
- Develop comprehensive treatment plans before a patient is discharged that clearly delineates procedures, medications, and responsibilities.
- Create an electronic health record immediately. The patch between AHLTA and VistA is several years in the making.
- Information on Social Security Disability Insurance and its availability to injured service members while they are still on active duty must be disseminated. (This provision of SSDI is not well known, and service members do not know to apply.)
- Reassess the effectiveness of Tricare for the severely disabled. The retired disabled who are transferred under Tricare for Life to Medicare after 2 years have to pay \$100 per month in premiums.

⁴⁶ Severely Injured, *Interim Report*, 1.

⁴⁷ *Ibid.*, 2.

- Review invitational travel orders for nonmedical attendants to return the disabled to the military treatment facilities for follow-up care.
- Review the combat stress control program and the lessons learned from OIF/OEF.
- Track TBI patients for present and future symptoms.
- Coordinate family services and support.
- Allow prorated retirement pay for severely injured personnel whose service was interrupted by injury.
- Require a durable power of attorney for all deploying service members and have three people designated for invitational travel orders..
- Allow severely injured service members to receive support in the form of “gifts” from nonprofits, under certain circumstances, and convene a task force on this ethical issue.
- Transmit DoD information to the states, especially in relation to treatment of PTSD and TBI and employment.
- Allow adaptive housing grants to be used more than once.
- Amend the Family and Medical Leave Act (FMLA) to include parents of injured troops over the age of 18.
- Allow rehabilitating severely injured personnel to attend military schools to obtain certification and training in occupations that are in higher demand than their current military occupational specialty and that translate more readily to the civilian sector.⁴⁸

VIII.2 Army Wounded Warrior Survey

To capture the issues and challenges of its severely injured soldiers and families, the Army Wounded Warrior (AW2) program conducted a survey and held symposiums. The most recent survey and symposium discovered the following information:⁴⁹

The top five priority issues were

1. retired wounded soldiers' eligibility for combat-related special compensation;
2. inadequate medical retirement pay for wounded warriors;
3. compensation for PTSD, TBI, and uniplegia;

⁴⁸ Severely Injured Marines and Sailors, *Final Report*,

⁴⁹ US Army, *Wounded Warrior*.

4. a benefit package (under Tricare) for nondependent primary caregivers of severely wounded; and
5. career opportunities for wounded warriors in government positions.

The top five transition concerns were

1. financial stability,
2. finding a job,
3. strain on loved ones,
4. inconsistencies in treatment and services by VA, and
5. low disability ratings from the Army.

The five most helpful sources of assistance were

1. spouse, family, and friends;
2. faith;
3. Army Wounded Warrior programs and services;
4. nonprofit organizations; and
5. VSOs and other veterans.

Other issues that did not make the top five, but were greatly discussed related to

- support and education for families, especially children;
- Medical Evaluation Board/Physical Evaluation Board education and case management assistance;
- access to specialty care (including women's health) at VA medical centers or outpatient clinics with improved case management;
- reimbursement of VA beneficiary travel expenses and accommodations; and
- SSDI eligibility for wounded warriors with less than the required quarters. (There are soldiers who have not worked long enough to be eligible before they were injured.)

Recommendation 10.14

DoD should consider the findings of the Severely Injured Marines and Sailors Program and the Army Wounded Warrior Survey.

Recommendation 10.15

DoD and VA should make transitioning service members aware of Social Security Disability Insurance.

Recommendation 10.16

Congress should consider eliminating the Social Security Disability Insurance minimum required quarters for severely injured service members.

IX Health Care

The Commission views health care as a primary benefit (along with compensation). Health care should be provided to disabled veterans to facilitate their rehabilitation, improve their quality of life, and expand their capacities to engage in usual life activities. A guiding principle of the Commission is that service-connected veterans should have access to a full range of health care at no cost, and their level of priority for receiving health care should be based on their degree of disability. Access to health care was often mentioned by veterans and their families during the public comment sessions of the Commission's meetings. It was also discussed in Commission meetings with VA and DoD leadership and field staff. The Commission visited VA centers for polytrauma, blindness, spinal cord injury, burns, amputee care, TBI, and PTSD. The health care budget of VA and DoD combined is \$51.5 billion, with 1,982 point-of-care sites, 333,000 staff, and 16.9 million beneficiaries (not unique users).⁵⁰

The mission of DoD Health Affairs is "to provide, and to maintain readiness to provide, health care services and support to members of the Armed Forces during military operations."⁵¹ DoD Health Affairs also provides care to eligible family members and retirees. The military health system is composed of 70 medical treatment facilities, over 800 clinics, and the Tricare network. The system has 9.2 million beneficiaries, and a \$20 billion budget.⁵²

Tricare is the DoD health care coverage program for active duty and retired uniformed services and their families. Tricare brings together the health care

⁵⁰ Data was compiled from the DoD AHLTA briefing provided to the Veterans' Disability Benefits Commission on November 17, 2006, and from VA's *Organizational Briefing Book*, 2006, and the *VA FY 2006 Performance and Accountability Report*.

⁵¹ Health Affairs Organization, *Responsibilities and Functions*.

⁵² DoD, "Tricare Management."

resources of the Army, Navy, Air Force, and Coast Guard with a network of civilian health care professionals.

Tricare divides the country into three regions with a fourth region overseas. The regions are covered by different insurance contractors whose competitive contracts come up for bid every few years. Transferring to other regions can be difficult. In areas where Tricare has military treatment facilities and an extensive network, access and quality is not as much an issue. In remote or rural areas, this can mean difficulty finding providers who will accept Tricare patients and are competent with military health issues. Many wounded soldiers have had to pay some of the costs of treatment for their combat-related wounds, a requirement that has been described as “adding insult to injury.”

Recommendation 10.17

DoD should remove Tricare requirements for copays and deductibles for the severely injured service members and their families.

In FY 2006, VA had 156 medical facilities, 877 clinics, 136 nursing homes, a staff of over 201,000 and a \$31.5 billion budget. It had over 7.7 million enrollees and treated 5.5 million unique patients, of whom 184,500 were OIF/OEF veterans.⁵³ (Vet Center contacts are not included in this data.) Since FY 2002, there have been 631,174 OIF/OEF veterans who have left active duty and became eligible for VA.⁵⁴ Enrollment in VA health care is not automatic for all separating service members. They must first make an application to the nearest VA facility and have their eligibility determined. OIF/OEF veterans have 2 years of open enrollment. There has been proposed legislation to extend this period to 5 years, since many medical conditions have a delayed onset or increase in severity. Extending enrollment would also allow those veterans who were unaware of or misunderstood their VA benefits at the time of their discharge more time to access the health care system.

Based on the current OIF/OEF VA user population, one prediction places the number of OIF/OEF veterans accessing VA care in 2014 at over 730,000 (of 1.5 million assumed discharges). This would also result in a projected increase in cost from \$1 billion to \$6.8 billion during that same time period.⁵⁵ Financial stresses will continue to be placed on the system as it has to provide quality long-term care, mental health, and polytrauma rehabilitation to several generations of disabled veterans with varying needs.

⁵³ VA, *2006 Annual Performance*, 1–2.

⁵⁴ VHA, *Analysis of VA Health Care*, 4.

⁵⁵ Bilmes, *Soldiers Returning*, 14.

Instituted in 1979, the Vet Centers provide readjustment counseling at 209 community-based locations nationwide with over 400 mental health providers. Readjustment counseling provides a wide range of services to all eras of combat veterans and their families to facilitate transition from military to civilian life. Services include individual, group, marital, family, PTSD, and bereavement counseling. Counselors also provide medical referrals, assistance in applying for VA benefits, employment counseling, alcohol and drug assessments, military sexual trauma counseling and referral, outreach, and community education.⁵⁶ In FY 2005, Vet Centers provided services to 125,737 veterans (67.4 percent being from the Vietnam era) who made more than a million visits.⁵⁷

In 2003, the VA Secretary extended Vet Center eligibility to OEF/OIF veterans. Subsequently, the Vet Centers hired 100 additional Global War on Terror (GWOT) outreach coordinators to encourage OIF/OEF veterans to come into the Vet Centers, network with members of the National Guard and Reserves and their families, and to provide post-deployment briefings in areas where units have returned from Iraq and Afghanistan. Since 2003, Vet Centers have provided services to a total of 156,787 OIF/OEF veterans, (outreach with 115,708, and treated 41,079) and provided grief counseling to 1,213 family members of approximately 800 service members killed on active duty.⁵⁸

The complex nature of some injuries and multiple body system damage being seen in Iraq and Afghanistan veterans has led VA to provide levels of care that are unprecedented and revolutionary. These programs are crucial to successful readjustment after military injury or illness, but they are resource intensive as they require a multidisciplinary approach with case managers and liaisons.

VHA is in the difficult position of having to balance the needs of a younger, sometimes severely injured population with the needs of its preexisting and aging patient population. This diversity places an even greater demand on resources in areas that already are resource intensive. Such diversity also requires staff to expand their expertise and perspective in treatment planning and program design to include issues such as technological assistance and job success strategies. Future veterans will need to continue to depend upon this diversity of care.

Recommendation 10.18

Maintain the accessibility and stability of quality health care for all disabled veterans.

⁵⁶ Vet Center, *Services Councilors Provide*.

⁵⁷ Batres, Interview.

⁵⁸ Batres, *Treatment of PTSD*.

Recommendation 10.19

VA and DoD should fund research in support of the needs of veterans from Operation Iraqi Freedom and Operation Enduring Freedom.

X Conclusion

Seamless transition is an admirable concept, but it does not fully exist at the present time. Transition has been described as needing to be seamless, integrated, and transparent to service members, veterans, and their families. But these concepts are elusive as the Departments and agencies that support the transition process have very different missions and statutory authorities. Successful readjustment boils down to the veteran needing services that are coordinated, complementary, and well communicated. A wide variety of health care and benefits are needed to help disabled veterans and their families with transition from military to civilian life. These services include medical and psychiatric care, housing, rehabilitation, employment services, compensation, education, and family support, particularly for the severely injured. Effective service delivery must be well coordinated and lead agents identified to ensure gaps are closed and duplication of effort is avoided. The ultimate vision of transition should be the continuation and fulfillment of a quality life for our nation's veterans, especially for those disabled while on active duty.

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The Way Forward: Findings and Recommendations

After two and a half years of studying veterans' benefits as they exist under the laws of the United States, the Commission developed an understanding of current policies and practices that go into effect as a disabled service member leaves the military and enters the system of the Department of Veterans Affairs (VA). The Commission achieved this understanding through a scrupulous process that included surveys, studies, literature and demographic reviews, legal analyses, site visits, expert testimony, and public comments. An array of federal benefits and services are available to disabled veterans; overall, these benefits are generous, healing, and demonstrative of the gratitude of this Nation. Some benefits are also available to veterans' dependents and survivors. The Commission assessed all of these benefits from the standpoints of their appropriateness, their level, and the standards by which they are granted.

Although disabled veterans can access some benefits and services from the Department of Labor when seeking employment and from the Social Security Administration when seeking disability insurance, the majority of benefits for disabled veterans are offered by VA. Other disability benefits come from the Department of Defense (DoD), which renders much of the transition assistance in the form of Transition Assistance Program briefings, retirement programs, and health care (through Tricare) for the severely injured and their families.

The Commission found that inconsistencies and gaps must be addressed for veterans' benefits to be delivered more efficiently and effectively. Based on its findings, the Commission offers guiding principles and recommendations to point the way forward for delivering benefits and services to disabled veterans and their families. The following is a summary of the Commission's findings and recommendations from each of the preceding chapters.

Chapter 4: Rating Process and System

At the heart of veterans' disability benefits is the VA Schedule for Rating Disabilities (Rating Schedule), which is used to identify a disabling condition and determine its level of severity. The Commission found the Rating Schedule to be

out of date and incongruous with current medical knowledge and practices in describing disabilities. This is especially true for mental disorders. The Rating Schedule lumps the 16 major diagnostic classes for mental disorders from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) into one body system. The Rating Schedule also relies on the Global Assessment of Functioning (GAF) Scale to judge the severity of mental disorders, and IOM found the GAF to be ineffective. VA should immediately begin to update the current Rating Schedule, beginning with the body systems addressing the evaluation and rating of posttraumatic stress disorder (PTSD), other mental disorders, traumatic brain injury, and the use of Individual Unemployability. VA should proceed through the entire Rating Schedule until it has been comprehensively revised. This revision process should be completed within 5 years. Then, VA should create a process for keeping the Rating Schedule up to date, including a published timetable and an advisory committee for revising criteria for each body system. This scheme should compensate for work disability, impairment of usual life activities, and loss in quality of life.

Chapter 5: Policies for Determining Eligibility for Benefits

Although the Commission has found some of the VBA claims policies to be appropriate such as with “reasonable doubt” and “line of duty,” there are other issues that need a great deal of attention, such as with presumptions, PTSD, and the simplification of its “duty to assist.”

Presumption issues should be dealt with using a four-level classification scheme (Sufficient, Equipose Above, Below Equipose, Against) that determines a causal effect. The Commission agrees with this scheme proposed by IOM, but cautions VA not to ignore evidence that shows an association between a condition and an environmental or occupational hazardous exposure. There should also be a scientific review board and advisory committee established that can focus on these hazards and their implications for service members and veterans. Beyond these steps, DoD needs an overall integrated environmental and occupational hazards surveillance strategy to monitor the health of service members.

To correct the demonstrated disparity in average loss of earnings capacity of veterans with PTSD and other mental disorders, VA should adopt new rating criteria specific to PTSD based on the DSM as previously noted when it updates the Rating Schedule. Furthermore, VA should establish a holistic approach that couples PTSD treatment, compensation, and vocational assessment, and reexamines those compensated for PTSD every 2 to 3 years to encourage treatment and wellness. Because PTSD is known to be a condition that can relapse and remit, VA should consider offering a baseline level of benefits to include health care as an incentive for recovery.

PTSD exams should be conducted by a qualified and experienced practitioner in a face-to-face interview using the DSM criteria and their judgment on psychological testing. At least an hour should be allotted for these exams.

These examiners and raters should be well trained and certified with new data made available to them, especially regarding PTSD, the application of the GAF Scale, and military sexual assault.

Chapter 6: Appropriateness of the Benefits

In addition to VA disability compensation, a spectrum of benefits is available to help disabled veterans return to the most productive lives possible after military service. These ancillary and special-purpose benefits include special monthly compensation; aid and attendance; automotive, housing, and clothing allowances; vocational rehabilitation; health care; insurances; and burial. The Commission found that in comparison to other programs in the United States and abroad, benefits for disabled veterans were inclusive and appropriate with two exceptions: the United States does not offer its veterans the same level of financial planning assistance or family support, especially for children, as do some other countries.

In relation to available ancillary benefits, the Commission found a few inconsistencies, primarily as they apply to veterans and active-duty service members with traumatic brain injury, severe burns, and polytrauma injuries. Changes are recommended to eliminate these inconsistencies.

The Vocational Rehabilitation and Employment (VR&E) program is underutilized, understaffed, and unable to effectively track its results. The young, wounded service members currently leaving the military could derive immediate assistance from this program, but the Commission fears they will miss the opportunity because of its weaknesses. The ability to perform the activities of daily living and to have improved functionality are important components of recovery. The VR&E program should be better equipped to help service-disabled veterans reach their goals of independent living, employment, or volunteerism. Recommendations to correct the flaws in the VR&E program include adding staff, improving performance measurement, expanding eligibility, and offering incentives for completing rehabilitation plans.

Finally, the Commission affirms that military retirement and VA disability are two different programs with different missions and payment offsets should cease. It also notes that for the severely injured who enter VA at a younger age, they do not financially keep pace with their peers and that these are the disabled veterans who most need concurrent receipt. Therefore, Congress should eliminate the ban on concurrent receipt for all military retirees and service members who separated from the military because of service-connected disabilities. Future priority should be given to veterans who separated or retired from the military under 10 U.S.C. chapter 61 with fewer than 20 years service and a service-connected disability rating greater than 50 percent, or a disability that is the result of combat.

Chapter 7: Appropriateness of the Level of Benefits

The Commission recognizes that Individual Unemployability (IU) is a means to accommodate individuals with multiple lesser ratings but who are unable to work because of their service-connected disabilities. As the Rating Schedule is revised, every effort should be made to accommodate individuals unable to work within the basic rating system without the need for an IU rating. Eligibility should be based on the individual's service-connected disabilities, in combination with education, employment history, and medical effects of age on potential employability. An assessment of employability should be made by vocational rehabilitation experts.

Compensation rates should be adjusted to reflect equity and quality of life. Initially, for severely disabled service members, VA should pay a fixed rate up to 50 percent of the basic monthly compensation rate for a 3-year period. This stabilization allowance would address the unexpected costs of recovery. Also, caregiver support should be coordinated with Traumatic Servicemembers' Group Life Insurance (TSGLI). To further deal with issues of equity, Congress should authorize VA to develop a payment scale based on age at the date of initial claim and degree of severity for severely disabled service members. In the future, Congress should adjust VA compensation levels for all disabled veterans using the best available data, surveys, and analysis to achieve fair and equitable levels of income compared to the nondisabled veteran. However, this should never result in a reduction of benefits to any veteran.

Next, regarding quality of life, the Commission agreed that VA should develop a quality-of-life payment. In the short term, Congress should increase the compensation rate up to 25 percent for the loss of quality of life, and in the future use that rate as a baseline for the development and implementation of a quality-of-life measure in the Rating Schedule. In developing a measure for the loss of quality of life, VA should take into account the loss of ability, functionality, and other non-work-related effects of disabilities on veterans and their family members.

After having established that the benefits are appropriate, the Commission evaluated whether the level of the benefit was also appropriate and found some deficiencies in this regard. Although most ancillary benefits have been adjusted in the last 5 years, others had not. Two benefits (beneficiary travel and Service-Disabled Veterans' Insurance) have not been adjusted since their inception decades ago. Additionally, the aid and attendance allowance should be adjusted to fully pay for the level of assistance required by the veteran. Therefore, Congress should bring the current ancillary and special-purpose benefits to the levels originally intended (by Congress) and provide for automatic annual adjustments to keep pace with inflation. Additionally, Congress should review the profound impact of disabilities on a veteran's quality of life, consider increasing special monthly compensation, and determine whether additional ancillary benefits are warranted. Finally, Congress should also change the

commencement date for the period of VA compensation payment to begin on the effective date of the award.

In its study on lump sum payments, the Commission saw on the surface some positive attributes to such a program. But, the complexities involved in delivering veterans' benefits, the shifting needs and circumstances of the veteran over time, and the large up-front costs and long break-even period, the Commission concluded that it would become too burdensome and inefficient for VA to create a lump sum payment program, and so recommended against it.

Chapter 8: Survivors and Dependents

Severely injured service members report that family support is the most important factor in their recovery. Some family members leave jobs, lose insurance, remortgage their homes, and neglect responsibilities and their own health to care for their wounded warrior. VA has limited means to support family members as caregivers. Therefore, Congress should authorize VA to establish and provide services for the families of severely injured veterans similar to those supplied by DoD, such as travel and per diem allowances. Congress should extend eligibility for the Civilian Health and Medical Program of VA to caregivers (if they are not already entitled as the veteran's dependent) and create a "caregiver allowance."

For survivors of retirees and in-service deaths, Congress should eliminate the offset between their Survivor Benefit Plan and Dependency and Indemnity Compensation. Additionally, VA should allow them, but not a creditor, to pursue the veteran's due, but unpaid benefits, and any additional benefits by continuing a claim that was pending when the veteran died, including presenting new evidence.

Chapter 9: Disability Claims Administration

The Veterans Benefits Administration provides compensation, vocational assistance, insurance, and burial. These benefits are not automatic. Veterans must file claims for these benefits and often that is a complex process that can take months or years before assistance is realized. VA should improve claims cycle time by establishing a simplified and expedited process for well-documented claims and using best business practices and maximum feasible use of information technology. VA should also allow a veteran to state that the claim is complete, and waive the time period (60 days) allowed for further development. Furthermore, VA should review the current duty-to-assist process and develop policies, procedures, technologies, and communications and ensure that they are efficient and effective from the perspective of the veteran. VA should consider amending Veterans' Claims Assistance Act letters by including all claim-specific information on the first page and all other legal requirements on a separate form or on subsequent pages. In particular, VA should use plain language in stating how veterans can request an early decision in their cases. It should also reduce the appellate workload by focusing on improved accuracy in

the initial decision-making process by ensuring that there are adequate resources to dispose of the existing workload on a timely basis, and the technology for electronic records transfer between field offices and the Board of Veterans Appeals. To accomplish these goals, Congress should mandate and provide the appropriate resources to reduce the VA claims backlog by 50 percent within the next 2 years.

Chapter 10: Transition

As disabled service members leave the military, they will encounter challenges during transition. Some of these are the Disability Evaluation System, Transition Assistance Program briefings, Benefits Delivery at Discharge (BDD), severely injured services, and a limited electronic transfer of their records from DoD to VA. The Commission has made several recommendations to improve this process.

DoD should realign the disability evaluation process and integrate it with VA. Under this intermediate system, the services would determine fitness for duty and those found unfit would be referred to VA for a disability rating determination. Furthermore, DoD should mandate that separation examinations be performed on all service members to ensure that all known conditions at the time of discharge are documented. Pending implementation of this new integrated system, all conditions that are identified as part of a single, comprehensive medical examination should be rated and compensated by DoD.

Congress should adequately fund and DoD should mandate the Transition Assistance Program briefings. This would ensure that all service members, including National Guard, Reserves, and medical hold patients are knowledgeable about benefits before leaving the military. They also should have greater access to the BDD process, and all service members should undergo a separation examination. Tricare copays and deductibles should be removed for the severely injured and their families to ensure their recovery from those injuries without financial burden.

The underlying philosophy for VA and DoD should be based on practices that support and encourage joint ventures, sharing agreements, and integration. VA and DoD should enhance their joint strategic plan to include specific milestones and designate a lead, responsible official, and involve the Department of Labor and the Social Security Administration in their collaborative efforts. Specifically, they should expedite implementation of compatible information technology systems and develop a detailed project management plan with specific milestones and lead agency assignment. DoD should be able to provide an authenticated electronic DD 214 to VA via this system. Ultimately, VA and DoD should improve record transfers. In the meantime, they must address issues of lost, missing, and unassociated paper records, as paper records will be a reality for many years to come.

VA and DoD should standardize a definition of the severely injured and compile a database of those individuals. They should also create an intensive case management program for severely disabled veterans with an identifiable lead agent to lessen the confusion for them and their families.

Conclusion

The Commission believes that if these actions are implemented, a system for future generations of disabled veterans and their families will be established that will ensure seamless transition and improve their quality of life.

In some instances, the Commission's analysis was impeded by the inability to acquire data. For future analytical purposes, VA and DoD should be directed to collect and study appropriate data with sufficient restrictions to ensure privacy. In addition, VBA should retain essential information on veterans to preserve each veteran's history of benefits. VA and DoD should be granted statutory authority to obtain data from the Social Security Administration and the Office of Personnel Management only for the purpose of periodically assessing the outcomes of benefit programs.

Finally, the Commission urges Congress to establish an executive oversight group to ensure timely and effective implementation of the outlined recommendations. This group should be cochaired by VA and DoD and should consist of senior representatives from appropriate departments and agencies. To measure and assess the progress of this Nation's ability to care for disabled veterans, it is further recommended that the Senate and House Veterans' Affairs Committees hold hearings and require annual reports on the status of implementing these recommendations. The Commission hopes disabled veterans will enjoy a better future as a result.

Accordingly, the Commission made Recommendation 11.1 as a comprehensive measure applying to all recommendations.

Recommendation 11.1

Congress should establish an executive oversight group to ensure timely and effective implementation of the Commission recommendations. This group should be cochaired by VA and DoD and should consist of senior representatives from appropriate departments and agencies. It is further recommended that the Veterans' Affairs Committees hold hearings and require annual reports to measure and assess progress.

Statement of Alternative Views

One Commissioner submitted a statement of separate views regarding four aspects of this report. His statement appears in Appendix L.

The Commission's Recommendations

Number ¹	Recommendation	Actionable By
CHAPTER 4		
4.1	The purpose of the current veterans disability compensation program as stated in statute currently is to compensate for average impairment in earning capacity, that is work disability. This is an unduly restrictive rationale for the program and is inconsistent with current models of disability. The veterans disability compensation program should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss in quality of life. (Specific recommendations on approaches to evaluating each consequence of service-connected injuries and diseases are in <i>A 21st Century System for Evaluating Veterans for Disability Benefits</i> , Chapter 4.) [IOM Rec. 3-1]	Congress
4.2	VA should compensate for nonwork disability, defined as functional limitations on usual life activities, to the extent that the Rating Schedule does not, either by modifying the Rating Schedule criteria to take account of the degree of functional limitation or by developing a separate mechanism. [IOM Rec. 4-5]	Congress

¹ Stars denote the highest-priority recommendations, as described in the Executive Summary.

Number ¹	Recommendation	Actionable By
4.3	VA should determine the feasibility of compensating for loss of quality of life by developing a tool for measuring quality of life validly and reliably in the veteran population, conducting research on the extent to which the Rating Schedule already accounts for loss in quality of life, and, if it does not, developing a procedure for evaluating and rating loss of quality of life in veterans with disabilities. [IOM Rec. 4-6]	VA
4.4	VA should develop a process for periodic updating of the disability examination worksheets. This process should be part of, or closely linked to, the process recommended above for updating and revising the Schedule for Rating Disabilities. There should be input from the disability committee recommended above (see IOM Rec. 4-1). [IOM Rec. 5-1]	VA
4.5	VA should mandate the use of the online templates that have been developed for conducting and reporting disability examinations. [IOM Rec. 5-2]	VA
4.6	VA should establish a recurring assessment of the substantive quality and consistency, or inter-rater reliability, of examinations performed with the templates and, if the assessment finds problems, take steps to improve quality and consistency, such as revising the templates, changing the training, or adjusting the performance standards for examiners. [IOM Rec. 5-3]	VA
4.7	The rating process should have built-in checks or periodic evaluations to ensure inter-rater reliability as well as the accuracy and validity of rating across impairment categories, ratings, and regions. [IOM Rec. 5-4]	VA
4.8	VA raters should have ready access to qualified health care experts who can provide advice on medical and psychological issues that arise during the rating process (e.g., interpreting evidence or assessing the need for additional examinations or	VA

Number ¹	Recommendation	Actionable By
	diagnostic tests). [IOM Rec. 5-5]	
4.9	Educational and training programs for VBA raters and VHA examiners should be developed, mandated, and uniformly implemented across all regional offices with standardized performance objectives and outcomes. These programs should make use of advances in adult education techniques. External consultants should serve as advisors to assist in the development and evaluation of the educational and training programs. [IOM Rec. 5-6]	VA
4.10	VA and the Department of Defense should conduct a comprehensive multidisciplinary medical, psychological, and vocational evaluation of each veteran applying for disability compensation at the time of service separation. [IOM Rec. 6-1]	VA and DoD
4.11	VA should sponsor research on ancillary benefits and obtain input from veterans about their needs. Such research could include conducting intervention trials to determine the effectiveness of ancillary services in terms of increased functional capacity and enhanced health-related quality of life. [IOM Rec. 6-2]	VA
4.12	The concept underlying the extant 12-year limitation for vocational rehabilitation for service-connected veterans should be reviewed and, when appropriate, revised on the basis of current employment data, functional requirements, and individual vocational rehabilitation and medical needs. [IOM Rec. 6-3]	VA
4.13	VA should develop and test incentive models that would promote vocational rehabilitation and return to gainful employment among veterans for whom this is a realistic goal. [IOM Rec. 6-4]	VA

Number ¹	Recommendation	Actionable By
4.14	In addition to medical evaluations by medical professionals, VA should require vocational assessment in the determination of eligibility for Individual Unemployability (IU) benefits. Raters should receive training on how to interpret findings from vocational assessments for the evaluation of IU claims. [IOM Rec. 7-1]	Congress and VA
4.15	VA should monitor and evaluate trends in its disability program and conduct research on employment among veterans with disabilities. [IOM Rec. 7-2]	VA
4.16	VA should conduct research on the earnings histories of veterans who initially applied for Individual Unemployability benefits past the normal age of retirement under the Old Age, Survivors, and Disability Insurance Program under the Social Security Act. [IOM Rec. 7-3]	VA
4.17	Eligibility for Individual Unemployability should be based on the impact of an individual's service-connected disabilities, in combination with education, employment history, and the medical effects of that individual's age on his or her potential employability. [IOM Rec. 7-4]	VA
4.18	VA should implement a gradual reduction in compensation to recipients of Individual Unemployability benefits who are able to return to substantial gainful employment rather than abruptly terminate their disability payments at an arbitrary level of earnings. [IOM Rec. 7-5]	VA
4.19	VA should adopt a new classification system using the <i>International Classification of Disease</i> (ICD) and the <i>Diagnostic and Statistical Manual of Mental Disorders</i> (DSM) codes. This system should apply to all applications, including those that are denied. During the transition to ICD and DSM codes, VA can continue to use its own diagnostic codes, and subsequently track and analyze them comparatively for trends affecting veterans and for program planning purposes. Knowledge of an applicant's	VA

Number ¹	Recommendation	Actionable By
	ICD or DSM codes should help raters, especially with the task of properly categorizing conditions. [IOM Rec. 8-1]	
4.20	Considering some of the unique conditions relevant for disability following military activities, it would be preferable for VA to update and improve the Rating Schedule on a regular basis rather than adopt an impairment schedule developed for other purposes. [IOM Rec. 8-2]	VA
4.21	VA should seek the judgment of qualified experts, supported by findings from current peer-reviewed literature, as guidance for adjudicating both aggravation of preservice disability and Allen aggravation claims. Judgment could be provided by VHA examiners, perhaps from VA centers of excellence, who have the appropriate expertise for evaluating the condition(s) in question in individual claims. [IOM Rec. 9-1]	VA
4.22	VA should guide clinical evaluation and rating of claims for secondary service connection by adopting specific criteria for determining causation, such as those cited above (e.g., temporal relationship, consistency of research findings, strength of association, specificity, plausible biological mechanism). VA should also provide and regularly update information to compensation and pension examiners about the findings of epidemiological, biostatistical, and disease mechanism research concerning the secondary consequences of disabilities prevalent among veterans. [IOM Rec. 9-2]	VA
* 4.23	VA should immediately begin to update the current Rating Schedule, beginning with those body systems addressing the evaluation and rating of posttraumatic stress disorder, other mental disorders, and traumatic brain injury. Then proceed through the other body systems until the Rating Schedule has been comprehensively revised. The revision process should be completed within 5	VA

Number ¹	Recommendation	Actionable By
	years. VA should create a system for keeping the Rating Schedule up to date, including a published schedule for revising each body system.	
CHAPTER 5		
5.1	Congress should change the character-of-discharge standard to require that when an individual is discharged from his or her last period of active service with a bad conduct or dishonorable discharge, it bars all benefits.	Congress
5.2	Maintain the present definition of line of duty: that service members are on duty 24 hours a day, 7 days a week.	No action required
5.3	Benefits should be awarded at the same level according to the severity of the disability, regardless of whether the injury was incurred or disease was contracted during combat or training, wartime or peacetime.	No action required
5.4	Maintain the current reasonable doubt standard.	No action required
5.5	Age should not be a factor for rating service connection or severity of disability, but may be a consideration in setting compensation rates.	No action required
5.6	Maintain the current standard of an unlimited time limit for filing an original claim for service connection.	No action required
5.7	DoD should require a mandatory benefits briefing to all separating military personnel, including Reserve and National Guard components, prior to discharge from service.	DoD
5.8	Congress should create a formal advisory committee (Advisory Committee) to the VA to consider and advise the Secretary of VA on disability-related questions requiring scientific research and review to assist in the consideration of possible presumptions. [IOM Rec. 1]	Congress and VA

Number ¹	Recommendation	Actionable By
5.9	Congress should authorize a permanent independent review body (Science Review Board) operating with a well-defined process that will use evaluation criteria as outlined in this committee's recommendations to evaluate scientific evidence for VA's use in considering future service-connected presumptions. [IOM Rec. 2]	Congress
5.10	VA should develop and publish a formal process for consideration of disability presumptions that is uniform and transparent and that clearly sets forth all evidence considered and the reasons for decisions reached. [IOM Rec. 3]	VA
5.11	The goal of the presumptive disability decision-making process should be to ensure compensation for veterans whose diseases are caused by military service and this goal must serve as the foundation for the work of the Science Review Board. The committee recommends that the Science Review Board implement its proposed two-step process. [IOM Rec. 4]	Congress
5.12	<p>The Science Review Board should use the proposed four-level classification scheme, as follows, in the first step of its evaluation. A standard should be adopted for "causal effect" such that if there is at least as much evidence in favor of the exposure having a causal effect on the severity or frequency of disease as there is evidence against, then a service-connected presumption will be considered. [IOM Rec. 5]</p> <ul style="list-style-type: none"> • Sufficient: The evidence is sufficient to conclude that a causal relationship exists. • Equipoise and Above: The evidence is sufficient to conclude that a causal relationship is at least as likely as not, but not sufficient to conclude that a causal relationship exists. • Below Equipoise: The evidence is not sufficient to conclude that a causal relationship is at least as likely as not, or is not sufficient to make a scientifically informed judgment. • Against: The evidence suggests the lack of a 	Congress

Number ¹	Recommendation	Actionable By
	causal relationship.	
5.13	A broad spectrum of evidence, including epidemiologic, animal, and mechanistic data, should be considered when evaluating causation. [IOM Rec. 6]	VA
5.14	When the causal evidence is at Equipoise and Above, an estimate also should be made of the size of the causal effect among those exposed. [IOM Rec. 7]	Congress
5.15	The relative risk and exposure prevalence should be used to estimate an attributable fraction for the disease in the military setting (i.e., service-attributable fraction). [IOM Rec. 8]	VA
5.16	Inventory research related to the health of veterans, including research funded by DoD and VA and research funded by the National Institutes of Health and other organizations. [IOM Rec. 9]	VA
5.17	Develop a strategic plan for research on the health of veterans, particularly those returning from conflicts in the gulf and Afghanistan. [IOM Rec. 10]	VA
5.18	Develop a plan for augmenting research capability within DoD and VA to more systematically generate evidence on the health of veterans. [IOM Rec. 11]	VA and DoD
5.19	Assess the potential for enhancing research through record linkage using the DOD and VA administrative and health record databases. [IOM Rec. 12]	VA and DoD
5.20	Conduct a critical evaluation of gulf war troop tracking and environmental exposure monitoring data so that improvements can be made in this key DoD strategy for characterizing exposures during deployment. [IOM Rec. 13]	DoD
5.21	Establish registries of service members and veterans based on exposure, deployment, and	VA and DoD

Number ¹	Recommendation	Actionable By
	disease histories. [IOM Rec. 14]	
5.22	Develop a plan for an overall integrated surveillance strategy for the health of service members and veterans. [IOM Rec. 15]	DoD
5.23	Improve the data linkage between the electronic health record data systems used by DoD and VA—including capabilities for handling individual soldier exposure information that is included as part of the individual's health record. [IOM Rec. 16]	VA and DoD
5.24	Ensure implementation of the DoD strategy for improved exposure assessment and exposure data collection. [IOM Rec. 17]	DoD
5.25	Develop a data interface that allows VA to access the electronic exposure data systems used by DoD. [IOM Rec. 18]	VA and DoD
5.26	DoD and VA should establish and implement mechanisms to identify, monitor, track, and medically treat individuals involved in research and other activities that have been classified and are secret. [IOM Rec. 19]	VA and DoD
5.27	VA should consider environmental issues such as blue water Navy and Agent Orange, Ft. McClellan and polychlorinated biphenyls, and Camp Lejeune and trichloroethylene/tetrachloroethylene in the new presumptions framework.	VA
* 5.28	VA should develop and implement new criteria specific to posttraumatic stress disorder in the VA Schedule for Rating Disabilities. Base those criteria on the <i>Diagnostic and Statistical Manual of Mental Disorders</i> and consider a multidimensional framework for characterizing disability caused by posttraumatic stress disorder.	VA
5.29	VA should consider a baseline level of benefits described by the Institute of Medicine to include health care as an incentive for recovery for	VA

Number ¹	Recommendation	Actionable By
	posttraumatic stress disorder as it relapses and remits.	
* 5.30	VA should establish a holistic approach that couples posttraumatic stress disorder treatment, compensation, and vocational assessment. Reevaluation should occur every 2–3 years to gauge treatment effectiveness and encourage wellness.	Congress and VA
5.31	<p>The posttraumatic stress disorder exam process:</p> <ul style="list-style-type: none"> • Psychological testing should be conducted at the discretion of the examining clinician. • VA should identify and implement an appropriate replacement for the Global Assessment of Functioning. <p>Posttraumatic stress disorder data collection and research:</p> <ul style="list-style-type: none"> • VA should conduct more detailed research on military sexual assault and PTSD and develop and disseminate reference materials for raters. 	VA and DoD
5.32	A national standardized training program should be developed for VA and VA-contracted clinicians who conduct compensation and pension psychiatric evaluations. This training program should emphasize diagnostic criteria for posttraumatic stress disorder and comorbid conditions with overlapping symptoms, as set forth in the <i>Diagnostic and Statistical Manual of Mental Disorders</i> .	VA
5.33	VA should establish a certification program for raters who deal with claims for posttraumatic stress disorder (PTSD), as well as provide training to support the certification program and periodic recertification. PTSD certification requirements should be regularly reviewed and updated to include medical advances and to reflect lessons learned. The program should provide specialized training on the psychological and medical issues (including comorbidities) that characterize the	VA

Number ¹	Recommendation	Actionable By
	claimant population, and give guidance on how to appropriately manage commonly encountered rating problems.	
CHAPTER 6		
6.1	Congress should consider increasing special monthly compensation where appropriate to address the more profound impact on quality of life by the disabilities subject to special monthly compensation and review ancillary benefits to determine where additional benefits could improve disabled veterans' quality of life.	Congress
6.2	The amount of payment for aid and attendance should be adjusted to fully pay for the extent of assistance required.	Congress
6.3	Extend aid and attendance to severely injured active-duty service members who are in a status pending discharge.	Congress
6.4	The automotive and housing adaptation benefit should be modified to cover service-connected veterans who need this assistance and are not currently eligible—for example, severe burn victims.	Congress
6.5	Provisions should be made to accommodate changing life circumstances by allowing a specially adapted housing grant at least twice.	Congress
6.6	Eliminate the premium paid by service members for Traumatic Servicemembers' Group Life Insurance.	Congress
6.7	The maximum amount of coverage should be increased and up-to-date mortality rates should be used to calculate premiums for Service-Disabled Veterans' Insurance.	Congress
6.8	Expand eligibility for the Veterans' Mortgage Life Insurance to include service members of the Armed Forces who have received housing modification grant assistance from VA for severely disabling conditions.	Congress

Number ¹	Recommendation	Actionable By
6.9	Access to vocational rehabilitation should be expanded to all medically separated service members.	Congress
6.10	All service disabled veterans should have access to vocational rehabilitation and employment counseling services.	Congress
6.11	All applicants for Individual Unemployability should be screened for employability by vocational rehabilitation and employment counselors.	Congress
6.12	The administration of the Vocational Rehabilitation and Employment Program should be enhanced by increased staffing and resources, tracking employment success beyond 60 days, and conducting satisfaction surveys of participants and employers.	VA
6.13	VA should explore incentives that would encourage disabled veterans to complete their rehabilitation plan.	VA
* 6.14	<p>Congress should eliminate the ban on concurrent receipt for all military retirees and for all service members who separated from the military because of service-connected disabilities. In the future, priority should be given to veterans who separated or retired from the military under chapter 61 with</p> <ul style="list-style-type: none"> • fewer than 20 years service and a service-connected disability rating greater than 50 percent, or • disability as a result of combat. 	Congress
CHAPTER 7		
7.1	Congress should authorize VA to revise the existing payment scale based on age at date of initial claim and based on degree of severity for severely disabled veterans.	Congress

Number ¹	Recommendation	Actionable By
7.2	Congress should adjust VA compensation levels for all disabled veterans using the best available data, surveys, and analysis in order to achieve fair and equitable levels of income compared to the nondisabled veteran.	Congress
7.3	VA and DoD should be directed to collect and study appropriate data, with due restrictions to ensure privacy. These agencies should be granted statutory authority to obtain appropriate data from the Social Security Administration and the Office of Personnel Management only for the purpose of periodically assessing appropriate benefits delivery program outcomes.	Congress
* 7.4	Eligibility for Individual Unemployability (IU) should be consistently based on the impact of an individual's service-connected disabilities, in combination with education, employment history, and medical effects of an individual's age or potential employability. VA should implement a periodic and comprehensive evaluation of veterans eligible for IU eligible. When appropriate, compensation should be gradually reduced for IU recipients who are able to return to substantially gainful employment rather than abruptly terminating disability payments at an arbitrary level of earning.	VA
* 7.5	Recognizing that Individual Unemployability (IU) is an attempt to accommodate individuals with multiple lesser ratings but who remain unable to work, the Commission recommends that as the Schedule for Rating Disabilities is revised, every effort should be made to accommodate such individuals fairly within the basic rating system without the need for an IU rating.	VA
* 7.6	Congress should increase the compensation rates up to 25 percent as an interim and baseline future benefit for loss of quality of life, pending development and implementation of a quality-of-life measure in the Rating Schedule. In particular, the measure should take into account the quality of life	Congress

Number ¹	Recommendation	Actionable By
	and other non-work-related effects of severe disabilities on veterans and family members.	
7.7	Congress should create a severely disabled stabilization allowance that would allow for up to a 50 percent increase in basic monthly compensation for up to 5 years to address the real out-of-pocket costs above the compensation rate at a time of need. This would supplement to the extent appropriate any coverage under Traumatic Servicemembers' Group Life Insurance.	Congress
* 7.8	Congress should consider increasing special monthly compensation, where appropriate, to address the more profound impact on quality of life of the disabilities subject to special monthly compensation. Congress should also review ancillary benefits to determine where additional benefits could improve disabled veterans' quality of life.	Congress
7.9	DoD should reassess the policy of allowing separation without compensation for individuals found unfit for duty who are also found to have a preexisting disability for up to 8 years of active duty.	DoD
7.10	VA and DoD should adopt a consistent and uniform policy for rating disabilities using the VA Schedule for Rating Disabilities.	VA and DoD
7.11	DoD should reassess the ratings of service members who were discharged as unfit but rated 0 to 30 percent disabled to determine if those ratings were equitable. (Note: Commission data only went back to 2000.)	DoD
* 7.12	VA and DoD should realign the disability evaluation process so that the services determine fitness for duty, and service members who are found unfit are referred to VA for disability rating. All conditions that are identified as part of a single, comprehensive medical examination should be rated and compensated.	Congress, VA, and DoD

Number ¹	Recommendation	Actionable By
* 7.13	Congress should enact legislation that would bring the ancillary and special-purpose benefits to the levels originally intended considering cost of living and provide for automatic annual adjustments to keep pace with cost of living.	Congress
7.14	VA disability benefits (including Traumatic Servicemembers' Group Life Insurance), except VA compensation benefits received in lieu of military retired pay, should not be considered in state court spousal support proceedings.	Congress
7.15	Lump sum payments should not be considered to compensate veterans for their disabilities.	No action required
CHAPTER 8		
8.1	Congress should extend eligibility for the Civilian Health and Medical Program of the Department of Veterans Affairs to caregivers and create a "caregiver allowance" for caregivers of severely disabled veterans.	Congress
* 8.2	Congress should eliminate the Survivor Benefit Plan/Dependency and Indemnity Compensation offset for survivors of retirees and in-service deaths.	Congress
8.3	Allow the veteran's survivors, but not a creditor, to pursue the veteran's due but unpaid benefits and any additional benefits by continuing the claim that was pending when the veteran died, including presenting new evidence not in VA's possession at the time of death.	Congress
CHAPTER 9		
* 9.1	<p>Improve claims cycle time by</p> <ul style="list-style-type: none"> • establishing a simplified and expedited process for well-documented claims, using best business practices and maximum feasible use of information technology; and • implementing an expedited process by which the claimant can state that the claim information is complete and waive the time period (60 days) allowed for further development. 	Congress and VA

Number ¹	Recommendation	Actionable By
	Congress should mandate and provide appropriate resources to reduce the VA claims backlog by 50 percent within 2 years.	
9.2	Change the commencement date for the period of payment to the effective date of the award. (See also Recommendation 10.7)	Congress
9.3	Reduce the appellate workload by focusing on improved accuracy in the initial decision-making process, enhance the appeals process by ensuring adequate resources to dispose of existing workload on a timely basis, and deploy technology for transferring electronic records between field offices and the Board of Veterans Appeals.	VA
9.4	VA should review the current duty to assist process and develop policy, procedures, and communications that ensure they are efficient and effective <u>from the perspective of the veteran</u> . VA should consider amending Veterans Claims Assistance Act letters by including all claim-specific information to be shown on the first page and all other legal requirements would be reflected, either on a separate form or on subsequent pages. In particular, VA should use plain language in stating how the claimant can request an early decision in his or her case.	VA
9.5	VBA regional office staff must receive adequate education and training. Quality reviews should be performed to ensure these frontline workers are well versed to rate claims. Adequate resources must be appropriated to hire and train these workers to achieve a manageable claims backlog.	Congress and VA
CHAPTER 10		
10.1	VA and DoD should enhance the Joint Executive Council's strategic plan by including specific milestones and designating an official to be responsible for ensuring that the milestones are reached.	VA and DoD

Number¹	Recommendation	Actionable By
10.2	The Department of Labor and the Social Security Administration should be included in the Joint Executive Council to improve the transition process.	VA and DoD
10.3	VA and DoD should jointly create an intensive case management program for severely disabled veterans with an identifiable lead agent.	VA and DoD
10.4	To facilitate seamless transition, Congress should adequately fund and mandate the Transition Assistance Program throughout the military to ensure that all service members are knowledgeable about benefits before leaving the service.	Congress
10.5	Benefits Delivery at Discharge should be available to all disabled separating service members (to include National Guard, Reserve, and medical hold patients).	VA and DoD
10.6	DoD should mandate that separation examinations be performed on all service members.	DoD
10.7	Disability payments should be paid from the date of claim.	Congress
10.8	DoD should expand existing programs that translate military occupational skills, experience, and certification to civilian employment.	DoD
10.9	DoD should provide an authenticated electronic DD 214 to VA.	DoD
10.10	VA and DoD should improve electronic information record transfers and address issues of lost, missing, and unassociated paper records.	VA and DoD
* 10.11	VA and DoD should expedite development and implementation of compatible information systems including a detailed project management plan that includes specific milestones and lead agency assignment.	VA and DoD

Number ¹	Recommendation	Actionable By
10.12	Congress should authorize and fund VA to establish and provide support services for the families of severely injured veterans similar to those provided by DoD.	Congress
10.13	DoD should standardize the definition of the term “severely injured” among the services and with VA, and create a common database of severely disabled service members.	VA and DoD
10.14	DoD should consider the findings of the Severely Injured Marines and Sailors Program and the Army Wounded Warrior Survey.	DoD
10.15	DoD and VA should make transitioning service members aware of Social Security Disability Insurance.	VA and DoD
10.16	Congress should consider eliminating the Social Security Disability Insurance minimum required quarters for severely injured service members.	Congress
10.17	DoD should remove Tricare requirements for copays and deductibles for the severely injured service members and their families.	DoD
10.18	Maintain the accessibility and stability of quality health care for all disabled veterans.	No action required
10.19	VA and DoD should fund research in support of the needs of veterans from Operation Iraqi Freedom and Operation Enduring Freedom.	VA and DoD
CHAPTER 11		
* 11.1	Congress should establish an executive oversight group to ensure timely and effective implementation of the Commission recommendations. This group should be cochaired by VA and DoD and should consist of senior representatives from appropriate departments and agencies. It is further recommended that the Veterans’ Affairs Committees hold hearings and require annual reports to measure and assess progress.	Congress

Appendix A

Laws and Charter Governing the Commission

This appendix contains the two laws governing the Commission—PL 108-136 and PL 109-163—and the Commission’s charter.

Laws Governing the Commission

PL 108-136

National Defense Authorization Act for Fiscal Year 2004

TITLE XV—VETERANS' DISABILITY BENEFITS COMMISSION

- Sec. 1501. Establishment of commission.
- Sec. 1502. Duties of the commission.
- Sec. 1503. Report.
- Sec. 1504. Powers of the commission.
- Sec. 1505. Personnel matters.
- Sec. 1506. Termination of commission.
- Sec. 1507. Funding.

SEC. 1501. ESTABLISHMENT OF COMMISSION.

(a) ESTABLISHMENT OF COMMISSION— There is hereby established a commission to be known as the Veterans' Disability Benefits Commission (hereinafter in this title referred to as the 'commission').

(b) MEMBERSHIP— (1) The commission shall be composed of 13 members, appointed as follows:

- (A) Two members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran who was awarded a decoration specified in paragraph (2).

- (B) Two members appointed by the minority leader of the House of Representatives, at least one of whom shall be a veteran who was awarded a decoration specified in paragraph (2).
 - (C) Two members appointed by the majority leader of the Senate, at least one of whom shall be a veteran who was awarded a decoration specified in paragraph (2).
 - (D) Two members appointed by the minority leader of the Senate, at least one of whom shall be a veteran who was awarded a decoration specified in paragraph (2).
 - (E) Five members appointed by the President, at least three of whom shall be veterans who were awarded a decoration specified in paragraph (2).
- (2) A decoration specified in this paragraph is any of the following:
- (A) The Medal of Honor.
 - (B) The Distinguished Service Cross, the Navy Cross, or the Air Force Cross.
 - (C) The Silver Star.
- (3) A vacancy in the Commission shall be filled in the manner in which the original appointment was made.
- (4) The appointment of members of the commission under this subsection shall be made not later than 60 days after the date of the enactment of this Act.
- (c) PERIOD OF APPOINTMENT— Members of the commission shall be appointed for the life of the commission. A vacancy in the commission shall not affect its powers.
- (d) INITIAL MEETING— The commission shall hold its first meeting not later than 30 days after the date on which a majority of the members of the commission have been appointed.
- (e) MEETINGS— The commission shall meet at the call of the chairman.
- (f) QUORUM— A majority of the members of the commission shall constitute a quorum, but a lesser number may hold hearings.
- (g) CHAIRMAN— The President shall designate a member of the commission to be chairman of the commission.

SEC. 1502. DUTIES OF THE COMMISSION.

- (a) STUDY— The commission shall carry out a study of the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service.
- (b) SCOPE OF STUDY— In carrying out the study, the commission shall examine and make recommendations concerning the following:
- (1) The appropriateness of such benefits under the laws in effect on the date of the enactment of this Act.
 - (2) The appropriateness of the level of such benefits.

(3) The appropriate standard or standards for determining whether a disability or death of a veteran should be compensated.

(c) CONTENTS OF STUDY— The study to be carried out by the commission under this section shall be a comprehensive evaluation and assessment of the benefits provided under the laws of the United States to compensate veterans and their survivors for disability or death attributable to military service, together with any related issues that the commission determines are relevant to the purposes of the study. The study shall include an evaluation and assessment of the following:

(1) The laws and regulations which determine eligibility for disability and death benefits, and other assistance for veterans and their survivors.

(2) The rates of such compensation, including the appropriateness of a schedule for rating disabilities based on average impairment of earning capacity.

(3) Comparable disability benefits provided to individuals by the Federal Government, State governments, and the private sector.

(d) CONSULTATION WITH INSTITUTE OF MEDICINE— In carrying out the study under this section, the commission shall consult with the Institute of Medicine of the National Academy of Sciences with respect to the medical aspects of contemporary disability compensation policies.

SEC. 1503. REPORT.

Not later than 15 months after the date on which the commission first meets, the commission shall submit to the President and Congress a report on the study. The report shall include the following:

(1) The findings and conclusions of the commission, including its findings and conclusions with respect to the matters referred to in section 1502(c).

(2) The recommendations of the commission for revising the benefits provided by the United States to veterans and their survivors for disability and death attributable to military service.

(3) Other information and recommendations with respect to such benefits as the commission considers appropriate.

SEC. 1504. POWERS OF THE COMMISSION.

(a) HEARINGS— The commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the commission considers advisable to carry out the purposes of this title.

(b) INFORMATION FROM FEDERAL AGENCIES— In addition to the information referred to in section 1502(c), the commission may secure directly from any Federal department or agency such information as the commission considers necessary to carry out the provisions of this title.

Upon request of the chairman of the commission, the head of such department or agency shall furnish such information to the commission.

(c) **POSTAL SERVICES**— The commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(d) **GIFTS**— The commission may accept, use, and dispose of gifts or donations of services or property.

SEC. 1505. PERSONNEL MATTERS.

(a) **COMPENSATION OF MEMBERS**— Each member of the commission who is not an officer or employee of the United States shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the performance of the duties of the commission. All members of the commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(b) **TRAVEL EXPENSES**— The members of the commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the commission.

(c) **STAFF**— (1) The chairman of the commission may, without regard to the civil service laws and regulations, appoint an executive director and such other personnel as may be necessary to enable the commission to perform its duties. The appointment of an executive director shall be subject to approval by the commission.

(2) The chairman of the commission may fix the compensation of the executive director and other personnel without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(d) **DETAIL OF GOVERNMENT EMPLOYEES**— Upon request of the chairman of the commission, the head of any Federal department or agency may detail, on a nonreimbursable basis, any personnel of that department or agency to the commission to assist it in carrying out its duties.

(e) **PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES**— The chairman of the commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the

annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

PL 109-163

National Defense Authorization Act for Fiscal Year 2006

SEC. 590. EXTENSION OF DATE OF SUBMITTAL OF REPORT OF VETERANS' DISABILITY BENEFITS COMMISSION.

Section 1503 of the National Defense Authorization Act for Fiscal Year 2004 (Public Law 108-136; 117 Stat. 1678; 38 U.S.C. 1101 note) is amended by striking "Not later than 15 months after the date on which the commission first meets," and inserting "Not later than October 1, 2007."

Charter Governing the Commission

Department of Veterans Affairs

Charter of the Veterans' Disability Benefits Commission

- A. OFFICIAL DESIGNATION: Veterans' Disability Benefits Commission.
- B. OBJECTIVES AND SCOPE OF ACTIVITY: In accordance with title XV of Public Law 108-136, the Commission shall carry out a study of the benefits under the laws of the United States that are provided to compensate and assist veterans and their survivors for disabilities and deaths attributable to military service. The Commission shall produce a report on the study.
- C. PERIOD OF TIME NECESSARY FOR THE COMMISSION TO CARRY OUT ITS PURPOSE: In accordance with section 590 of Public Law 109-163, the Commission is expected to complete its work not later than October 1, 2007.
- D. RECIPIENTS OF THE COMMISSION'S REPORT: The Commission is directed to submit its final report to the President and Congress.
- E. AGENCY RESPONSIBLE FOR PROVIDING NECESSARY SUPPORT TO THE COMMISSION: The Department of Veterans Affairs shall provide all necessary funding support to the Commission. Other support, to include

detailing of federal employees, is described in section 1505 of Public Law 108-136.

F. DUTIES OF THE COMMISSION: The Commission's study shall be a comprehensive evaluation and assessment of benefits provided under current federal laws to compensate veterans and their survivors for disability or death attributable to military service. In carrying out the study, the Commission shall make recommendations concerning the appropriateness of such benefits under existing laws, the appropriateness of the level of such benefits, and the appropriate standard or standards for determining whether a veteran's disability or death should be compensated. The Commission shall also consult with the Institute of Medicine of the National Academy of Sciences with respect to the medical aspects of contemporary disability compensation policies.

The Commission may hold hearings, take testimony, and receive any evidence it considers advisable to carry out its purposes. The Commission may also secure from any federal department or agency such information as it considers necessary to carry out its purposes.

The Commission shall be composed of 13 members appointed by the President and by the leaders of the Senate and the House of Representatives. Of the 13 total members, not less than 7 shall be veterans who were awarded any of the following decorations: the Medal of Honor, the Distinguished Service Cross, the Navy Cross, the Air Force Cross, and the Silver Star. Members of the Commission shall be appointed for the life of the Commission.

Each member of the Commission who is not an officer or employee of the United States shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day during which the member is engaged in the performance of the duties of the Commission. The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter 1 of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

G. ESTIMATED ANNUAL OPERATING COSTS IN DOLLARS AND STAFF-YEARS: Operational support for the Commission is estimated at \$2 million per year and approximately 8 staff-years. The chair of the Commission may appoint an executive director and such other personnel as may be necessary to enable the Commission to perform its duties. The rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of title 5, United States Code.

H. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS: The Commission will meet as often as is necessary to carry out its assigned duties

and responsibilities. The Designated Federal Officer (DFO) will approve the schedule of Commission meetings. The DFO or a designee will be present at all meetings, and each meeting will be conducted in accordance with an agenda approved by the DFO. The DFO is authorized to adjourn any meeting when he or she determines it is in the public interest to do so.

I. COMMISSION TERMINATION DATE: The Commission shall terminate 60 days after the date on which it submits its final report to the President and Congress.

J. DATE CHARTER IS FILED:

-- Signed --
2/21/07

Approved: _____
R. James Nicholson
Secretary of Veterans Affairs

Date: _____

Appendix B

Biographical Sketches of the Commissioners

James Terry Scott, Lieutenant General, U.S. Army (Retired) Chairman

Date Appointed to the Commission: May 20, 2004.

Work Experience: Chairman Terry Scott is a partner at Watson & Associates, a financial services firm located in Coleman, Texas. He joined the firm in 2001. He also teaches political science at Howard Payne University in Brownwood, Texas. He is a member of the Board of Directors of the Calibre Corporation, a technical services company based in Alexandria, Virginia. From 1997 through 2001, he was the director of the National Security Program at the John F. Kennedy School of Government, Harvard University. He directed programs for senior government executives and lectured in graduate and executive education courses on national security matters and issues. He joined the faculty at Harvard in January 1997 after more than 32 years in the U.S. Army. He remains a member of some Harvard-affiliated national security study groups and committees, including the Executive Committee on Domestic Preparedness.

Military Service: His military experience includes command of tactical units at all levels, from platoon through division. Key staff assignments include service with the West Point faculty; speech writer and editor in the Office of the Chief of Staff, Army; and Deputy for Plans and Policy, U.S. Pacific Command. He served in six foreign countries and participated in five combat tours, three of which were in Vietnam where he served as an infantry platoon leader, company commander, and operations officer. Key senior command positions included duties as commanding general, Special Operations Command Europe, with responsibility for all joint special operations in Europe and Africa (1987–1989); Assistant Division Commander, 24th Infantry Division (Mechanized), throughout Operations Desert Shield and Desert Storm in Saudi Arabia and Iraq (1989–1991); and Commanding General, 2nd Infantry Division, in the Republic of Korea (1991–1993). From 1993 until his retirement from the Army in 1996, Chairman Scott was Commanding General of U.S. Army Special Operations Command at Fort

Bragg, North Carolina. In this position, he was responsible for all Army Special Operations Forces, both Active and Reserve. His command participated in operations in Somalia, Haiti, and the Balkans, as well as in counterterrorism and counternarcotics missions worldwide. Chairman Scott is a qualified combat infantryman, master parachutist, and Army Ranger.

Medals for Valor and Awards for Outstanding Service: Chairman Scott earned five awards for valor, including two awards of the Silver Star and two awards of the Purple Heart for wounds received in combat.

Educational Attainment: Chairman Scott received a master of business administration (magna cum laude) from Fairleigh-Dickinson University and a bachelor degree from Texas A&M University. His military education includes the Infantry Officer Advanced Course, the Army Command and Staff College, and the Army War College.

Personal: Chairman Scott is married to the former Carol Wilson of Coleman, Texas. They have two daughters, Amanda and Lisa, who also live in Texas.

Nick D. Bacon, First Sergeant, U.S. Army (Retired)

Date Appointed to the Commission: March 24, 2004.

Work Experience: Commissioner Bacon is currently serving on the President's National Hire Veterans Committee. He is the former director of the Arkansas Department of Veterans' Affairs, a Veterans Affairs Representative, and city manager of Surprise, Arizona (1987–1990). He has served as the president of the Congressional Medal of Honor Society (2001–2003) and with the VA Regional Office in Phoenix, Arizona (1984–1986). He is also cofounder and co-ordinator of the Med-Vet Healthcare Program in Phoenix, Arizona (1987–1990).

Commissioner Bacon is also a member of the American College of Forensic Examiners International (Certified in Homeland Security, level V), The American Legion, Military Order of the Purple Heart, Disabled American Veterans, Veterans of Foreign Wars (with appointments as national aide-de-camp), Arkansas Veterans Commission, and National Security Council of The American Legion. He held a position as board member of the Arkansas Aviation Historical Society and Aerospace Education Center.

Military Service: United States Army, 1963–1984.

Medals for Valor and Awards for Outstanding Service: Commissioner Bacon is a Congressional Medal of Honor recipient for his heroic actions west of Tam Ky, in the Republic of Vietnam. He has also received the Distinguished Service Cross, Legion of Merit, Bronze Star, Combat Infantry Badge, Purple Heart, Army

Commendation Medal, Good Conduct Medal, Viet Nam Cross of Gallantry, Viet Nam Campaign Medal, National Defense ribbon, Army Service Ribbon, and four overseas ribbons.

Commissioner Bacon was recognized with the George Washington Award from the State of Arizona (1986), Outstanding Young American (1977), The American Legion Honor Award, FBI Civilian Academy, American Academy of Medical Administrators Statesman Award, Minuteman Award, 82nd Airborne Iron Mike Award, Omar Bradley Award for the Congressional Medal of Honor Society, and others.

Educational Attainment: High school; basic law enforcement; associate of science in political science; U.S. Office of Personnel Management, Dealing with the Public; Lee De Borris School of Dallas, Texas.

Military schools and courses include First Sergeant Academy; Noncommissioned Officers Academy; Military Police Customs School, language: basic German; Counterterrorism School; Military Police Supervisors Course; Combat Medical Course; U.S. Army Recruiting School; Commanders / First Sergeant Initial Training Course; Station Commanders Course; Sniper School; Heavy Weapons Infantry.

Personal: Born in Caraway, Arkansas, Commissioner Bacon is married to Tamera Ann and has three sons and two daughters, as well as four grandchildren.

Larry G. Brown, Colonel, U.S. Army (Retired)

Date Appointed to the Commission: July 9, 2004.

Work Experience: Commissioner Brown is currently flying as a civilian pilot in CH 54 heli-tankers during wildfire season throughout the United States.

Military Service: Prior to his retirement from the Oregon Army National Guard AGR program in 1996, Commissioner Brown was assigned as the deputy chief for personnel. He also served as training officer in the 1st Battalion, 162nd Infantry; S2/S3 officer for the 1st Battalion, 249th Anti-Armor LT; Department G3 Rear 82nd Reserve Training Officer Corps, I Corps; executive officer of the 82nd Brigade, and commander of the 3rd Battalion, 186th Infantry Anti-Armor, with the Oregon Army National Guard.

Commissioner Brown received his direct commission as a second lieutenant in 1968. Prior to his commissioning, he served as a warrant officer following his graduation from Helicopter Flight School in 1967. His active duty assignments included scout team leader, B Troop, 1/9 Cavalry, 1st Cavalry Division, Vietnam;

instructor pilot, Fort Wolters, Texas; scout section leader, C Troop, 3/17th Cavalry, 1st Aviation Brigade, Vietnam; scout platoon leader, E Troop, 1/9 Cavalry, 1st Cavalry Division; flight platoon commander, 249th Aviation Company (Heavy Helicopter), Finthen, Germany.

Medals for Valor and Awards for Outstanding Service: Commissioner Brown's awards include the Silver Star with a second oakleaf cluster, Legion of Merit, Distinguished Flying Cross with a third oakleaf cluster, Bronze Star, Purple Heart with a third oakleaf cluster, and other awards and service recognition.

Educational Attainment: Commissioner Brown graduated from Battle Ground High School in Battle Ground, Washington. In 1965, he graduated from Clark Junior College, Vancouver, Washington, with an associate's degree in drafting and design. In 1992, Commissioner Brown graduated from Eastern Oregon State College with a bachelor of science degree.

His military education includes attendance at the U.S.A. Flight School, Armor Officer Basic Course, Infantry Officer Advance Course, and Command and General Staff College.

Personal: Born in Pensacola, Florida, Commissioner Brown is married to Colonel Carol A. Brown. His daughter, Kelly lives in McMinnville, Oregon. One son Larry is a captain assigned to the 2nd Brigade, 4th Infantry Division, at Fort Carson, Colorado, and son John lives in Colorado Springs, Colorado.

Jennifer Sandra Carroll, Lieutenant Commander, U.S. Navy (Retired)

Date Appointed to the Commission: May 20, 2004.

Work Experience: Commissioner Jennifer Carroll is the former executive director of the Florida Department of Veterans' Affairs. She was responsible for the claims and benefits of over 1.8 million veterans. In fiscal year 2001, under her leadership, more than \$63 million in retroactive compensation was awarded to Florida's veterans. She was also responsible for the agency's \$30 million budget, legislation, three state nursing homes and one domiciliary for the veterans in Florida. She was also the chairperson for Florida's Council on Homeless.

In 2001, President George W. Bush appointed her to the White House Presidential Scholar's Commission. In 2003, Commissioner Carroll won her election for State House of Representatives District 13 and was subsequently reelected unopposed. She is the first African-American female Republican ever to be elected to the Florida Legislature. Currently she is the chairperson of the Financial Institution Committee, and a member of the Jobs and Entrepreneurship

Council, Homeland Security and Public Safety Committee, and Select Committee on Affordable Housing.

Military Service: Commissioner Carroll enlisted in the Navy in 1979. She rose through the ranks from an enlisted jet mechanic and retired as a lieutenant commander, aviation maintenance officer, after 20 years.

Medals for Valor and Awards for Outstanding Service: Commissioner Carroll received numerous personal awards and decorations during her 20-year military career, including the Meritorious Service Medal, two Navy Commendation Medals, two Navy Achievement Medals, and many others. Commissioner Carroll has received numerous awards for her community service. She received the 2007 Pioneer Award from the National Black Republican Association, 2006 Clay County Citizen of the Year, 2005 Orange Park Rotary Club Citizen of the Year Award, and BAMPAC's Vikki Buckley Political Leadership Award. She was selected as the 2004 Legislator of the Year by the Northeast Florida Realtors Association, and she received the 2001 Center for New Black Leadership Excellence in Leadership Award, the 1998 First Coast African-American Women Award, the 1996 Clay County Chamber of Commerce Military Person of the Year, and the 1996 YMCA Black Achievers Award.

Educational Attainment: Commissioner Carroll graduated from Uniondale High School, Uniondale, New York, in 1977, and holds a bachelor degree in political science from the University of New Mexico.

Personal: Commissioner Carroll resides in Clay County and is married to Mr. Nolan Carroll. They have three children.

Donald M. Cassidy, Colonel, U.S. Air Force (Retired)

Date Appointed to the Commission: March 24, 2004.

Work Experience: Since his retirement from the United States Air Force (USAF) in 1977, Commissioner Don Cassidy has worked predominantly in academia for North Park University in Chicago, Illinois, and for Aurora University in Aurora, Illinois. He retired in 2004 as director of operations for the School of Business and Nonprofit Programs at North Park University, where he regularly taught courses in ethical leadership and strategic management, change management, diversity and conflict, and business policy. Commissioner Cassidy presided over the merger of undergraduate and graduate business programs and the integration of the Axelson Center for Nonprofit Management into the new School of Business and Nonprofit Management, which he then directed.

While at Aurora University, he planned, established, and launched the School of Business, where he served as the dean. He also served as Dean of Graduate

Studies and Director of Development, coached wrestling, served as the judge of the resident halls council, and managed the college's veterans affairs office.

From 1985 to 1998, Commissioner Cassidy was the vice president of corporate development for Merchants National Bank in Aurora, Illinois. He was in charge of managing a cultural change from a traditional banking business to a modern customer-oriented banking organization. He assisted in significantly altering the organization, both structure and culture, while the bank's footings grew by approximately 30 percent and improved return on assets from .75 percent to 1.16 percent.

Military Service: After graduation from college, Commissioner Cassidy was commissioned as a regular officer in the United States Air Force. He rose to the rank of full colonel in 16 years.

He trained as a fighter pilot but was assigned to bombers where he flew more than 1,000 hours in the B-47 during the height of the Cold War. He served as maintenance officer in the Strategic Air Command; executive to the comptroller of the USAF Headquarters Command; chief of maintenance for the 3rd Air Force in Ruislip, England, where he was responsible for the logistic portions of integrating the F-111 fighter-bomber into the command; director of maintenance policies and procedures for Headquarters United States Air Forces Europe in Wiesbaden, Germany; instructor at the Air War College having been selected to remain on faculty after graduating from the Air War College; director of aircraft and missiles programs under the deputy chief of staff logistics, HQ USAF, the Pentagon, responsible for developing and managing \$8 billion in logistic programs each year, which included designing the programs, presenting them to the Department of Defense, Office of Management and Budget, and Congress.

Medals for Valor and Awards for Outstanding Service: During his 20 years of service, Commissioner Cassidy was awarded two Meritorious Service Medals; six Air Force Commendation Medals; two Outstanding Unit Citations; the National Defense Service Medal, and seven marksman's ribbons.

Educational Attainment: Commissioner Cassidy received a bachelor degree in history from Grinnell College in Iowa. He graduated with a master of science in management from Colorado University and was honored as a distinguished graduate of the USAF Squadron Officers School and Air War College. He also attended the Royal Air Force Staff College in the United Kingdom and the Institute for Educational Management at Harvard University.

Personal: Commissioner Cassidy has been married for 48 years to the former Rosalie J. Yeoman. They have three grown daughters and four grandsons. His hobbies include reading, traveling, gardening, and woodwork. He is currently serving as immediate past president of the B-47 Stratojet Association.

John Holland Grady

Date Appointed to the Commission: May 20, 2004.

Work Experience: Commissioner Grady worked for 37 years providing actuarial services for pension plans and other employee benefit and financial programs. Geographically, his career included periods in Boston, San Francisco, Denver, New York, and Dallas. His experience included working with Fortune 100 companies as well as small businesses. The bulk of his career was spent as a partner with Coopers & Lybrand, PricewaterhouseCoopers, and finally as a principal with Mellon Financial Corp. His employment responsibilities at times included practice office leadership and national leadership for standards of actuarial practice. Commissioner Grady retired in June 2005.

In 1984, President Reagan appointed Commissioner Grady to the Department of Defense Retirement Board of Actuaries. This three-member board is charged with responsibility for the actuarial methods and assumptions applied in the funding of the retirement, disability, and survivor benefits provided by the military retirement system. This appointment was completed in 2002.

In 1985, the Secretary of Defense appointed Commissioner Grady to the Department of Defense Education Benefits Board of Actuaries, which has responsibility for the actuarial aspects of the Education Benefits Fund. This appointment was completed in 2002.

Educational Attainment: In 1968, Commissioner Grady received a bachelor degree in math from Harding University in Searcy, Arkansas, and in 1973, he completed the professional requirements to become a fellow of the Society of Actuaries.

Personal: Commissioner Grady is married to Robbi Grady, and they have two children. Having moved from Dallas in June 2005, they now reside in Boulder, Colorado, where he enjoys beekeeping, tennis, and hiking.

Charles E. “Butch” Joeckel, Jr.

Date Appointed to the Commission: March 23, 2004.

Work Experience: Commissioner “Butch” Joeckel presently serves as an accredited veterans representative for the National Veterans Legal Services Program headquartered in Washington, DC. From 1974–1992, he served in many capacities with the Disabled American Veterans (DAV) as a national service officer, legislative assistant, assistant national legislative director, deputy national legislative director, national director of services, executive director of

DAV's Washington headquarters, and as national adjutant—chief executive officer of DAV.

Each of these capacities required Commissioner Joeckel to be keenly aware of the benefits and services provided to our Nation's veterans. He is responsible for many expansive provisions presently in law that extend benefits to our most severely disabled veterans, himself a bilateral above-the-knee leg amputee of the Vietnam War. Wounded during the Tet Offensive, Commissioner Joeckel has been an advocate for veterans for some 36 years since his return from Vietnam in 1968.

More recently, Commissioner Joeckel served as executive director of Help Disabled War Veterans, an organization affiliated with Help Hospitalized Veterans (HHV), which provides personal computers, without charge, to veterans who are more or less housebound, thereby connecting them to the world outside their homes. In addition, he served as special projects director of HHV, ensuring the continuance of the provision of computers to our most severely disabled veterans. He also served as a staff member of the President's Task Force To Improve Access to Health Care For Our Nation's Veterans.

Presently, Commissioner Joeckel is the executive producer of the American Veterans Awards (AVA) Show in Hollywood, California, a program that recognizes distinguished veterans from all walks of life, our Nation's military, the National Guard and Reserves, as well as military families.

Military Service: Commissioner Joeckel served in the Marine Corps during the Vietnam War and was wounded during the Tet Offensive in 1968.

Medals for Valor and Awards for Outstanding Service: Commissioner Joeckel lost both of his legs above the knees in a land mine explosion during an engagement with the enemy. He was awarded the Silver Star, Navy Commendation Medal with the combat valor device, the Purple Heart, and other meritorious awards for action in Vietnam.

Educational Attainment: Commissioner Joeckel received an associate of arts degree from Prince George's Community College in Largo, Maryland (after service in Vietnam). In 1972 he matriculated in political science at Towson State College in Maryland, and from 1974 to 1976 rehabilitated under VA's Vocational Rehabilitation Program.

Personal: Commissioner Joeckel has personally benefited from nearly every health care and educational training program provided by the Department of Veterans Affairs and Department of Defense. For the past 36 years, he has represented veterans in one capacity or another. Having experienced the traumas of war, injury, recovery, and rehabilitation, and having overcome his severe disability, he is, indeed, amply qualified to pass on the various issues

confronting our Nation's commitment to its Armed Forces personnel and subsequently our Nation's veterans.

He is married to the former Dianne L. Jackson, whom he met at Bladensburg High School, a 1967 graduate, and the couple presently resides in Naples, Florida. They have three children and six grandchildren.

Ken Jordan, Colonel, United States Marine Corps (Retired)

Date Appointed to the Commission: June 24, 2005.

Work Experience: Commissioner Ken Jordan has executive-level experience in the government and corporate sectors in a wide array of fields, including operations management, staff functioning, mergers and acquisitions, strategic planning, human resource operations, and career transition consulting.

After retiring from the Marine Corps in 1988, he was immediately employed by Bank of America in their corporate headquarters in San Francisco. As a vice president and manager in corporate human resources, Commissioner Jordan managed multiple levels of managers with offices located throughout the country. He actively participated in 23 mergers, acquisitions, and divestitures, and was directly involved in strategic planning. He left Bank of America in 1997 and returned to San Diego.

In January 1998, Commissioner Jordan was certified as a career transition counselor for Lee Hecht Harrison, an international company that provides career advice and assistance to employees as part of a severance plan when they depart a company. Because of his experience at the executive level both in government and in the commercial sector, he primarily specialized in the senior programs. During his association with Lee Hecht Harrison, Commissioner Jordan has consulted over 600 senior and executive-level professionals in the career transition process.

Commissioner Jordan has written numerous magazine articles, newspaper editorials, and book reviews on a wide array of topics. He is an experienced instructor and public speaker, and is active in charitable, nonprofit organizations that provide service to the community.

He served on the board of directors of the United States Olympic Committee; the editorial board of the *Marine Corps Gazette*, a professional magazine; is past president of the Force Recon Association, a worldwide organization composed of former Marine Corps Special Operations professionals; was chairman of the board of the Marine Memorial Association in San Francisco, which encompasses an exquisite hotel, theatre, restaurant, and fitness facility for over 20,000 association members worldwide; past chairman of the board of directors of the

USO of San Diego, representing the largest number of active duty military and their families of any USO in the Nation; a director of the MCRD Museum and Historical Society; a member of the board of governors of the Marine Corps Association in Quantico, Virginia; an appointee to the Secretary of the Navy Retiree Advisory Council. Commissioner Jordan also served as a director for the Veterans Medical Research Foundation, a not-for-profit research organization dedicated to funding and conducting medical research in support of the Veterans Affairs Medical Center in San Diego.

Military Service: Commissioner Jordan retired from the Marine Corps as a colonel with extensive command and staff experience encompassing combat service in Vietnam and command from platoon to regimental level. He commanded a force reconnaissance company in Vietnam, and during his second tour in Vietnam and Okinawa served as the operations officer for an infantry battalion. His other assignments include command of a recruiting station, command of an infantry battalion, and command of the recruit training regiment (boot camp) in San Diego, plus various headquarters and staff tours. He retired from the Marine Corps in 1988, as the director of personnel of the Marine Corps in Washington, DC.

Medals for Valor and Awards for Outstanding Service: As a U.S. Marine, Commissioner Ken Jordan is a recipient of the Silver Star, for valor in combat, in addition to two Legion of Merit Awards and a variety of other military awards. At Bank of America he received the CEO's Eagle Award for exemplary performance in the mergers and acquisitions environment.

In 1999, Commissioner Jordan was inducted into the Athletes Hall of Honor at his university, in recognition of his lifetime achievements as a former collegiate athlete.

In 2002, he was inducted as a distinguished graduate by his university, the highest honor the university can bestow on an alumnus in recognition of lifetime accomplishments.

Educational Attainment: Commissioner Jordan graduated from Sam Houston State University in Texas with a degree in business administration and has completed numerous management courses both in the Federal government and the corporate sectors.

Personal: Commissioner Jordan and his wife, Lee Ann, live in San Diego, California, and they have two daughters, both former collegiate athletes. Kristi is a school teacher in Seattle, Washington, was an honorable mention All American swimmer, and is married to a medical doctor, also a collegiate All American swimmer; and Leslie, an All Conference runner in track and field in college and a summa cum laude graduate, is in the psychology field working as a case worker and counselor in Seattle.

James E. Livingston, Major General, United States Marine Corps (Retired)

Date Appointed to the Commission: May 20, 2004.

Work Experience: Commissioner Jim Livingston currently works as a consultant for defense matters and on numerous boards of for-profit and nonprofit organizations.

Military Service: Commissioner Livingston retired on September 1, 1995, following over 33 continuous years on active duty in the United States Marine Corps. His last assignment was as commander of the Marine Forces Reserve in New Orleans, Louisiana.

Following advancement to brigadier general on June 10, 1988, he served as deputy director for operations at the National Military Command Center in Washington, DC. During Operations Desert Shield and Desert Storm, Commissioner Livingston commanded the Marine Corps Air Ground Combat Center, 29 Palms, California, and developed the Desert Warfare Training Program. After commanding the 1st Marine Expeditionary Brigade, he was advanced to Major General on July 8, 1991, and assumed command of the newly created Marine Reserve Force, and continued through its reorganization in October 1994 with its new title, Marine Forces Reserve.

Medals for Valor and Awards for Outstanding Service: On May 2, 1968, while serving as the commanding officer, Company E, 2nd Battalion, 4th Marines, he distinguished himself above and beyond the call of duty in action against enemy forces and earned the Congressional Medal of Honor. His decorations also include the Distinguished Service Medal; Silver Star Medal; Defense Superior Service Medal; Bronze Star Medal, with combat valor device; Purple Heart, third award; Defense Meritorious Service Medal; Meritorious Service Ribbon, second award; Navy Commendation Medal with combat valor device; Combat Action Ribbon, second award; and various other service and foreign decorations. He is also a qualified military parachutist.

Educational Attainment: Commissioner Livingston is a graduate of the Amphibious Warfare School, the Marine Corps Command and Staff College, and the Air War College.

Personal: Commissioner Livingston is a native of Towns, Georgia, and is married to the former Sara Craft. They have two daughters, Kimberly and Melissa. Kimberly, a graduate of the U.S. Naval Academy and Medical University of South Carolina, is currently assigned to the Navy Medical Center in

San Diego, California, as a staff dermatologist. Melissa is a graduate from Tulane University and works for Blue Cross/Blue Shield.

William M. Matz, Jr., Major General, U.S. Army (Retired)

Date Appointed to the Commission: September 27, 2005.

Work Experience: Upon retirement from the U.S. Army in September 1995, Commissioner Bill Matz worked eight years in the defense industry. He was first employed by Raytheon Company, where he moved from a program manager to vice president, Army programs. Upon leaving Raytheon, he took over as program general manager for Vinnell/Northrop Grumman's Saudi Arabian National Guard Modernization Program in Riyadh, Saudi Arabia, returning to the United States in June 2004.

Commissioner Matz currently serves as the president of the National Association for Uniformed Services (NAUS). NAUS was founded in 1968 and is the only military-affiliated association that represents the entire military and veteran family. No other association provides such broad representation when dealing with Congress, the White House, and the Pentagon. NAUS represents all seven branches of the uniformed services including the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration including all components (Active Duty, Reserve, National Guard), retired and other veterans, their spouses, widows and widowers, other family members and survivors, and all grades and ranks—both enlisted and officer.

Military Service: Upon his graduation from Gettysburg College in Pennsylvania, Commissioner Matz was commissioned as a second lieutenant and assigned to the 82nd Airborne Division. Following this initial assignment, he served along the demilitarized zone of Korea with the 1st Battalion, 8th Cavalry, 1st Cavalry Division, and 2nd Battalion, 23rd Infantry, 2nd Infantry Division, successively as a rifle company commander and battalion S3. Upon his return from Korea, he was assigned to the Ranger Department, U.S. Army Infantry School. In October 1967, he arrived in Vietnam and served as a rifle company commander with the 3rd Battalion, 47th Infantry, 9th Infantry Division, in the Mekong Delta, where he was wounded in action during the 1968 Tet Offensive.

Upon return from Vietnam, he was assigned as assistant professor of military science, ROTC Department, Middlebury College, Vermont. Commissioner Matz returned to WESTPAC in June 1970, where as plans/special operations officer on the Afloat Staff, Amphibious Forces, Pacific Fleet, he participated in amphibious operations along the Vietnam coast. In June 1973, he was assigned to the Strategy, Plans and Policy Directorate, Office of the Deputy Chief of Staff for Operations and Plans (ODCSOPS), DA, as a strategic planner and

director executive officer until assuming command of the 3rd Battalion, 187th Infantry, 101st Airborne Division, in July 1977. In 1980, he returned to the 82nd Airborne Division and served as division G3 from June 1980 to July 1982. Following this assignment, he returned to Korea where he served as chief, Force Development Division, G3/J3, 8th Army/U.S. Forces Korea Staff.

In 1983, he assumed command of the 4th Training Brigade, U.S. Army Armor School. Upon relinquishing command in 1985, he returned to the Army Staff as deputy director, Training Directorate, ODCSOPS. This was followed by a tour of duty as executive secretary to the Secretary of Defense. In August 1988, he became the assistant division commander, support, 7th Infantry Division (Light), and deployed with the division to Panama on Operation JUST CAUSE. MG Matz assumed duties as the deputy commanding general, U.S. Army Pacific, in February 1990. He then served as the deputy commanding general and interim commanding general of I Corps and Fort Lewis from January 1992 until his retirement from the U.S. Army in September 1995.

Medals for Valor and Awards for Outstanding Service: Among his awards and decorations are the Distinguished Service Cross; Defense Distinguished Service Medal; Distinguished Service Medal; Silver Star; Defense Superior Service Medal; Legion of Merit with three oakleaf clusters; Bronze Star with the combat valor device; Purple Heart; and the Combat Infantryman Badge.

Educational Attainment: Commissioner Matz is a graduate of the Infantry Officer Basic and Advanced Courses, the Airborne and Ranger Courses, the Command and General Staff College, and the Army War College. He received a bachelor degree in political science from Gettysburg College and a master of arts degree in political science from the University of San Diego.

Personal: Commissioner Matz was born in Drexel Hill, Pennsylvania. He and his wife, Linda, reside in Great Falls, Virginia, and are the parents of three married children.

Dennis V. McGinn, Vice Admiral, U.S. Navy (Retired)

Date Appointed to the Commission: February 10, 2004.

Work Experience: Admiral McGinn is senior vice president and general manager of the Energy, Transportation, and Environment Division at Battelle Memorial Institute. He first joined Battelle as vice president for strategic planning in 2002, following retirement after 35 years with the U.S. Navy. He is actively engaged in national forums to highlight the close link between energy and international security, as well as the imperative for innovative policies and more effective deployment of technology to create a high-quality, sustainable global environment. Admiral McGinn serves on the board of directors of Brookhaven

Science Associates, the board of directors of the National Conference on Citizenship, the board of advisors of the American Council on Renewable Energy, and is a senior fellow for international security at the Rocky Mountain Institute.

Military Service: A naval aviator, test pilot, and national security strategist, Commissioner McGinn has served in a broad range of operational, staff, and command billets.

Operational tours at sea include two combat deployments aboard the aircraft carrier USS *Ranger*, flying strike missions with Attack Squadron 113 while serving as landing signal officer and weapons officer. He served as operations and maintenance officer in Attack Squadron 146 aboard the USS *Constellation* and as executive officer of the USS *Coral Sea*.

Shore and staff assignments include air warfare officer at VX-5, China Lake, California, and chief test pilot, Strike Directorate, Naval Air Test Center, Patuxent River, Maryland. He attended the Naval War College, the Program for Senior Officials in National Security at Harvard University, and served as a chief of naval operations fellow on the Strategic Studies Group. Commissioner McGinn's first flag assignment was as chief, information systems and chief negotiator, Allied Command Restructuring, Supreme Headquarters Allied Powers, Europe.

Command experience includes tours as commanding officer of Light Attack Weapons School, commanding officer of Attack Squadron 27 during two deployments aboard the USS *Coral Sea*, commanding officer of Strike Fighter Squadron 125, flying F/A 18 Hornets, and commanding officer of the fleet replenishment oiler, USS *Wichita*.

From 1991 until July 1993, he served as commanding officer of the aircraft carrier USS *Ranger* making an extended western Pacific and Indian Ocean deployment. In 1995 Commissioner McGinn served as commander, Carrier Group One, responsible for the operational training and combat readiness of all Pacific Fleet Carrier Battle Groups. In January 1996, Commissioner McGinn was assigned as director, Air Warfare Division in the headquarters of the Chief of Naval Operations where he was responsible for all policy, planning, programming, and budgeting for naval aviation. In November 1998, Commissioner McGinn assumed duties as the 20th commander of the U.S. 3rd Fleet. Based aboard the USS *Coronado*, he was responsible for the safety, training, and readiness of all naval ships, submarines, and aviation squadrons operating in the Eastern Pacific Ocean and served as the Pacific Command's joint force commander for joint warfare experimentation.

In October 2000, Commissioner McGinn assumed duties in the Pentagon as the first deputy chief of naval operations, warfare requirements and programs (N6/N7), responsible for determining needed future naval combat capabilities and

for deploying systems to fully enable joint network centric operations. He held additional duties as the Navy's executive agent for technology experimentation and rapid prototyping and as the director of ForceNet, the principal element of the Navy's Sea Power 21 Strategy.

Educational Attainment: Commissioner McGinn is a native of Attleboro, Massachusetts, and a graduate of the U.S. Naval Academy and the Naval Test Pilot School. He was a fellow at the Naval War College on the Strategic Studies Group and attended the national security program at the Kennedy School of Government, Harvard University.

Rick Surratt (Former U.S. Army)

Date Appointed to the Commission: January 21, 2004.

Work Experience: Commissioner Rick Surratt, a combat-disabled Vietnam veteran, was named deputy national legislative director of the million-member Disabled American Veterans (DAV) at the 1998 DAV national convention in Las Vegas.

Commissioner Surratt is employed at DAV National Service and Legislative Headquarters in Washington, DC. As a member of the DAV's legislative team, he works to promote reasonable and responsible legislation to assist disabled veterans and their families, as well as guarding current veteran's benefits and services from legislative erosion.

Commissioner Surratt joined the DAV's professional DAV national service officer (NSO) staff at the Roanoke office in 1976, working there until 1989 when he was assigned to the DAV national appeals staff at the VA Board of Veterans Appeals in Washington, DC. Later that year, he was assigned to the DAV office at the U.S. Court of Veterans Appeals as a judicial appeals representative. He moved to the DAV National Service and Legislative Headquarters when he was named associate national legislative director in 1994. In 1996 he was appointed assistant national legislative director, and served in that capacity until his current appointment.

Military Service: Commissioner Surratt enlisted in the U.S. Army in 1966. In 1967, he was wounded by shell fragments in the thigh during a Vietnam combat field operation, while serving with the 101st Airborne Division. He was honorably discharged in 1969.

Joe Wynn (Former U.S. Air Force)

Date Appointed to the Commission: July 9, 2004.

Work Experience: Commissioner Joe Wynn is the legislative liaison and a lifetime member of the National Association for Black Veterans (NABVETS). NABVETS is a veteran service organization headquartered in Milwaukee, Wisconsin, with over 35 chapters around the country; it has existed for more than 35 years.

Since receiving an honorable discharge from the U.S. Air Force in 1974, Commissioner Wynn has been an advocate of veterans' initiatives. He has served on the executive committee of the Veterans Entrepreneurship Task Force (VET-Force) since 1999, and has assisted the Service Disabled Veterans Business Association with its mission of providing employment and entrepreneurial opportunities for service-disabled veterans. At one point, he was the program manager responsible for oversight of the facilities' operations, maintenance, and custodial services for the Department of Veterans Affairs' headquarters building in Washington, DC.

He currently serves as the chairman of the Armed Services and Veterans Affairs Committee for the Washington, DC, branch of the NAACP; as a member of the NABVETS National Command Council; and as a member of the Mayor's Veterans Advisory Board for the District of Columbia.

Commissioner Wynn is also the president of the Veterans Enterprise Training and Services Group (VETS Group), a nonprofit organization formed to provide entrepreneurial education, supportive services, training, and advocacy for veterans interested in starting or expanding their own small businesses.

Military Service: Commissioner Wynn served as the administrative specialist for the 66th Strategic Missile Squadron of missile flight officers, stationed at Ellsworth Air Force Base in Rapid City, South Dakota, during the Vietnam era. He also served on the Human Relations Council.

Educational Attainment: Under the GI Bill, Commissioner Wynn attended the University of DC and Howard University. He received a bachelor degree in computer information systems, a master of business degree, and has completed 2 years toward a doctorate in organizational communications. He later served as an instructor and the director of education at the PTC Career Institute, a business school in Washington, DC.

Awards: Commissioner Wynn received the Small Business Administration's Veteran Small Business Champion Award for 2005 for the Washington, DC, region, and he received the NAACP's 2006 Julius E. Williams Distinguished Community Service Award for Veteran's Services.

Personal: Commissioner Wynn is a lifetime member of St. George's Episcopal Church in Washington, DC, and is married to Mrs. Margaret E. Wynn. Together they have five children and seven grandchildren.

Appendix C

Research Questions

Public Law 108–136 created the Commission and charged it with carrying out a comprehensive study of the appropriateness of the benefits provided under laws of the United States to veterans and their survivors to compensate and provide assistance for the effects of disabilities and deaths attributable to military service. The evaluation and assessment was required to include the purpose of the benefits, the appropriateness of their levels and payment rates under the law and VA schedule for rating disabilities, and the appropriateness of the policies for determining eligibility for compensation. The Commission also was charged with studying any related issues that it deemed relevant to the purpose of developing its findings and recommendations.

To structure its inquiry, the Commission developed the research questions presented below. The process of formulating the questions began when the Department of Veterans Affairs (VA) commissioned Economic Systems Inc. (ESI) to report on the literature and legislative history pertinent to VA's Disability Compensation Program. The recurring themes and concerns that ESI identified served as a springboard from which the Commission considered dozens of issues regarding disability compensation for veterans, their dependents, and their survivors. Those issues fell into three broad categories: Compensation; Duty–Service Connection; and Transition, Coordination, and Readjustment. The Commission then broke into three subcommittees, one for each category. Relevant subject-matter experts briefed the subcommittees to deepen their understanding of the issues. Each subcommittee then translated its set of issues into research questions and reported them to the full committee for approval. These questions formed the foundation of the Commission's inquiry into benefits for veterans and their survivors to compensate and provide assistance for the effects of disabilities and deaths attributable to military service.

The research questions:

1. How well do benefits provided to disabled veterans meet Congressional intent of replacing average impairment in earnings capacity?
2. How well do benefits provided to disabled veterans meet implied Congressional intent to compensate for impairment in quality of life due to service-connected disabilities?

3. How well do benefits provided to survivors meet implied Congressional intent to compensate for the loss of the veterans/service members' earning capacity and for the impairment in quality of life due to service-connected death?
4. How well do benefits provided to disabled veterans and survivors meet implied Congressional intent to provide incentive value for recruitment and retention?
5. Should the benefits package be modified?
 - a. Would the results be more appropriate if reduced quality of life and lost earnings were separately rated and compensated?
 - b. Are there negative unintended consequences resulting from the current benefit structure? Does the receipt of certain levels of compensation provide a disincentive to work or undergo therapy?
 - c. To what extent should VA modify its compensation policies if data from certain categories of service-connected veterans demonstrate little or no measurable loss of earning capacity and/or quality of life?
6. How well do the medical criteria in the VA Rating Schedule and VA rating regulations enable assessment and adjudication of the proper levels of disability to compensate for both the impact on quality of life and impairment in earnings capacity?
7. How does the adequacy of disability benefits provided for members of the Armed Forces compare with disability benefits provided to employees of Federal, State, and local governments, and commercial and private-sector benefit plans?
8. How do the operations of disability benefits programs compare?
 - a. The role of clinicians in the claims and appeal processes, and the required number of staff for this function.¹
 - b. The role of attorneys and legal staff in the claims and appeals processes, and the required number of staff for this function.
 - c. Compensation Claims Process
 - Steps/cycles in the process
 - Location and number of processing centers
 - Administrative costs, i.e., discretionary spending – staffing, information technology, other.
 - Performance indicators (timeliness, quality, inventory, etc.)
 - d. Appeals Process
 - Steps/cycles in the process
 - Location and number of processing centers

¹ Presentation by Colonel Martin Tittle, United States Army Physical Disability Agency, July 22, 2005.

- Administrative costs, i.e., discretionary spending – staffing, information technology, other.
- Performance indicators (timeliness, quality, inventory, etc.)
- e. Training and certification of staff and client representatives
 - Required initial training
 - Required refreshed training
- f. Quality Assurance/Control Program

9. Pertinent law and regulations require that disability compensation be based on average impairment of earnings capacity, not on loss of individual earnings capacity.

- a. Would the results be more appropriate if factors such as the individual's military rank, military specialty, pre-service occupation, education, and skill level were taken into consideration in determining benefits?
- b. Would the results be more appropriate if the effect of the veteran's medical condition on his or her occupation were taken into consideration in determining benefits?

10. Should lump sum payments be made for certain disabilities or level of severity of disabilities? Should such lump sum payments be elective or mandatory? Consider the merits under different circumstances such as where the impairment is to quality of life and not to earnings capacity.

11. Should universal medical diagnostic codes be adopted by VA for disability and medical conditions rather than using a unique system? Should the VA Schedule for Rating Disabilities be replaced with the American Medical Association Guides to the Evaluation of Permanent Impairment?

12. Are benefits available to service disabled veterans at an appropriate level if not indexed to cost of living and/or locality? Should the various benefits that are presently fixed be automatically adjusted for inflation?

13. Should VA's definition for "line of duty" change? If so, how?

14. To what extent, if any, should VA policies relating to presumptive conditions be changed?

15. Should certain rating principles related to service connection be modified? (see questions below) (38 CFR 3.303 (a))

- a. To what extent, if any, should "age" factor into determining entitlement to service connected compensation?
- b. To what extent should the benefit of the doubt rule be reconsidered or redefined?

- c. To what extent should service connection on a “secondary” basis be redefined?
 - d. To what extent should service connection on an “aggravation” basis be redefined?
16. Do changes need to be recommended for the Individual Unemployability (IU) benefit?
17. Because Vocational Rehabilitation and Employment (VR&E) benefits are an integral part of the compensation package for many service connected veterans, what changes, if any, are needed in this program?
18. Should there be a time limit for filing an original claim for service connection? (does not include claims for service connection on a presumptive basis)
19. Currently, a pending claim terminates at the time of the veteran’s death even when dependents remain. To what extent, if any, should this law be changed?
20. Certain criteria and/or levels of disability are required for entitlement to ancillary and special purpose benefits. To what extent, if any, do the required thresholds need to change?
21. What recommendations, if any, should the Commission make in regards to Concurrent Receipt policies?
22. Should the Commission explore and recommend changes to the “duty to assist” law? If so, how?
23. Should the Commission explore the Character of Discharge Standard?
24. Should compensation payments be protected from apportionments and garnishments?
25. In regards to Post Traumatic Stress Disorder (PTSD), what policy changes, if any, need to be recommended?
26. To what extent is the coordination between the Department of Veterans Affairs (VA) and the Department of Defense (DoD) adequate to meet the needs of service members/veterans, particularly the needs of service-connected disabled veterans?
27. To what extent is the coordination for seriously injured and disabled service members/veterans adequate within VA between the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA) and internally within each of the Administrations? What are the internal and external impediments, challenges and gaps, and how might these barriers be overcome?

28. To what extent is the coordination adequate within DoD between the Office of the Secretary of Defense for Personnel and Readiness, Health Affairs and Force Management Policy, and the branches of Service? What are the internal and external impediments, challenges and gaps and how might these barriers be overcome?
29. To what extent do DoD and VA provide disabled members/veterans the means and the opportunity to succeed in their transition to civilian life? What are the adequacy, quality, and timeliness of the benefits provided by each agency?
30. What policy and cultural shifts must be made to produce a common, shared, bi-directional data exchange of information and access to medical and personnel records between VA and DoD and within VA between VBA and VHA?
31. To what extent are the training, education and outreach programs (of DoD, VA, and DOL) adequate to ensure that the greatest number of active duty, Guard and Reserve personnel are informed of the full range of Federal government veteran benefits and services and provided tools such as a statement of education and military occupational specialties experiences adaptable to civilian job searches?

Appendix D

Summary of Site Visits

Groups of Commissioners and staff visited point-of-service and point-of-care facilities of the Department of Veterans Affairs (VA) and the Department of Defense (DoD) in eight cities during 2006 (Box D-1) to gain an empirical understanding of the distribution of disability benefits to veterans, service members, and their families. Also, town hall meetings were held in each city so that veterans, service members, survivors, and interested members of the public could express their opinions and concerns directly to the Commissioners.

Box D-1
Locations and Dates of the Commission's Eight Site Visits

1. Tampa/St. Petersburg, Florida	February 15–17, 2006
2. San Antonio, Texas	March 6–8, 2006
3. Chicago	April 11–13, 2006
4. St. Louis, Missouri	May 9–11, 2006
5. San Diego, California	June 5–7, 2006
6. Seattle, Washington	July 18–20, 2006
7. Boston	August 2–4, 2006
8. Atlanta	September 5–7, 2006

Two criteria were established to select the locations of the site visits:

1. Areas that have relatively large populations of veterans and service members
2. A concentration of VA and DoD facilities, including VA regional offices, military installations, Vet Centers, VA medical centers, and Benefit Delivery at Discharge sites.

Given these criteria, staff developed a list of numerous potential locations, and the Commissioners each selected their top eight sites. The final choices were the highest-ranking sites of all the Commissioners.

All of the Commissioners and staff participated in the introductory visit to Tampa and St. Petersburg, where the group received detailed briefings on VA benefits and services. Then teams of three Commissioners and one staff member visited the other seven cities. Table D-1 identifies the organizations that the teams either visited or received briefings from.

Table D-1. Facilities Visited in Each City

CITY	VBA FACILITIES	VHA FACILITIES	DOD FACILITIES
Tampa and St. Petersburg	<ul style="list-style-type: none"> • Regional office 	<ul style="list-style-type: none"> • Bay Pines VAMC^a • Tampa VAMC 	<ul style="list-style-type: none"> • MacDill Air Force Base
San Antonio	<ul style="list-style-type: none"> • Benefits office • QTC^b 	<ul style="list-style-type: none"> • Audie Murphy VAMC • Tejeda outpatient clinic 	<ul style="list-style-type: none"> • Brooke Army Medical Center, Intrepid Rehab Center • Lackland Air Force Base
Chicago	<ul style="list-style-type: none"> • Regional office 	<ul style="list-style-type: none"> • VISN^c 12 office • Hines VAMC • N. Chicago VAMC • Jesse Brown VAMC • Oak Park Vet Center 	<ul style="list-style-type: none"> • Great Lakes Naval Base
St. Louis ^d	<ul style="list-style-type: none"> • Regional office • Records Management Center 	<ul style="list-style-type: none"> • Jefferson Barracks VAMC 	<ul style="list-style-type: none"> • Army Human Resource Command
San Diego	<ul style="list-style-type: none"> • Regional office 		<ul style="list-style-type: none"> • Camp Pendleton • Naval Medical Center San Diego
Seattle	<ul style="list-style-type: none"> • Regional office 	<ul style="list-style-type: none"> • VA Puget Sound Health Care System • Limb Loss Center of Excellence • Seattle Vet Center 	<ul style="list-style-type: none"> • Ft. Lewis • Madigan Army Medical Center
Boston	<ul style="list-style-type: none"> • Regional office 	<ul style="list-style-type: none"> • Jamaica Plain VAMC • National Center PTSD • Boston Vet Center 	<ul style="list-style-type: none"> • Hanscom Air Force Base
Atlanta and Augusta	<ul style="list-style-type: none"> • Regional office 	<ul style="list-style-type: none"> • VISN 7 • Atlanta VAMC • Rehab Research and Development Center • Augusta VAMC • Atlanta Vet Center 	<ul style="list-style-type: none"> • Fort Gordon • Eisenhower Army Medical Center • Active Duty Rehab Center

^a VAMC = VA Medical Center

^b QTC is a private contract provider and not a government agency.

^c VISN = Veteran Integrated Service Network.

^d In St. Louis, the team also visited the National Personnel Records Center, a unit of the National Archives and Records Administration—not part of VA or DoD.

I Town Hall Meetings

Regional town hall meetings gave the Commissioners access to veterans, families, survivors, service members, and the general public. In turn, the public and service members who attended the meetings could learn the Commission's goals and research questions (Appendix C).

At least 853 individuals attended the eight town hall meetings. More than 180 attendees voiced comments to the Commissioners, while about a dozen others submitted statements for the record. The public's concerns covered a range of issues, from access to VA benefits and services to personal experiences filing claims and waiting on appeals. Individuals voiced concerns about environmental and occupational hazards (such as Agent Orange, depleted uranium, and PCBs), the contracting of exams to QTC, and mental health treatment, especially for posttraumatic stress disorder (PTSD). They also expressed perceived inadequacies of the VA Rating Schedule, concurrent receipt, garnishment, veterans' preference, and cost of living increases. In addition, they called for improvement of survivor benefits and protection of the Individual Unemployability benefit, and discussed confusion that arose from certain types of letters from VA.

During the town meetings, staff from the local VA regional offices and VA medical centers, as well as from DoD, were on hand to offer support to the public and provide interventions as needed.

II Regional Offices of the Veterans Benefits Administration

The Veterans Benefits Administration (VBA), a division of VA, maintains at least one regional office in each state. The Commission teams visited a VBA regional office in every city¹ on their itineraries.

The two most prominent issues that arose during visits to the regional offices were timeliness and quality of claims processing. To measure differences in timeliness among the regional offices, three of the more commonly used VBA

¹ The VBA regional office for Texas is in Houston, not in San Antonio (which the Commissioners visited), but data from the Houston office are included here for purposes of comparison.

measures were selected that reflected fiscal year-to-date data as of August 2006. Measures chosen for this purpose were average days to complete a claim and number of pending cases (i.e., backlog).

While in San Antonio, Seattle, Atlanta, and Boston, the Commission teams met with QTC Management, a VBA contractor that performs compensation and pension (C&P) exams.

II.1 VBA Regional Office Veterans Service Centers

At the Veterans Service Centers, the Commission teams met with all levels of personnel involved in claims processing, including decision review officers, rating veterans service representatives, veteran service representatives, and coaches. Service center employees explained their operational challenges to the Commission teams. Staff of the Atlanta regional office discussed the potential value of using artificial intelligence to rate certain body systems, producing a quick disability rating, and generating all necessary forms. Similar suggestions were made at other VA locations visited by the Commission.

II.2 VBA Regional Office Vocational Rehabilitation and Employment Sites

During the Commission's introductory site visit to Tampa–St. Petersburg, the Commissioners received a briefing on the mission, eligibility, and structure of the vocational rehabilitation and employment (VR&E) program. Commissioners then met with VR&E staff at the other seven sites to discuss program operations, successes, and challenges.

III Veterans Service Organizations

The Commission teams met with representatives from numerous veterans service organizations, including The American Legion, AMVETS, Disabled American Veterans, Paralyzed Veterans of America, Veterans of Foreign Wars, Vietnam Veterans of America, and Military Order of the Purple Heart, among others. Topics of discussion included communicating with VA regional office staff, duty-to-assist letters, Veterans Claims Assistance Act letters, the quality of disability ratings, the potential for DoD and VA to use a single rating exam, timeliness of claims processing, transition assistance, survivor benefits, and experiences working with QTC, a private provider of government-outsourced occupational health and disability examination services.

IV VA Medical Centers

At the VA medical centers, the visiting Commissioners toured units for burn care, rehabilitation of the blind, and the treatment of polytrauma, spinal cord injury, traumatic brain injury, and amputation. The Commissioners toured such unique facilities as the Center for Excellence in Limb Loss & Prosthetics in Seattle, the Rehabilitation Research Center in Atlanta, the National Center for PTSD and the Women's Health Division in Boston, and the Federal Healthcare Facility at Great Lakes (which is the first fully integrated VA/DoD facility).

In meetings with medical and hospital directors, the Commissioners learned how those leaders were balancing the treatment and rehabilitation of service members recently wounded in Afghanistan and Iraq with the provision of long-term care to aging veterans and those needing mental health services.

IV.1 Compensation and Pension Examiners

While visiting the VA medical centers, the Commissioners spent most of their time gathering information from the compensation and pension (C&P) examiners to help assess the appropriateness of benefits and how those benefits are delivered. The physician-examiners discussed issues regarding communication, timeliness, and productivity of C&P exams; the use of electronic templates; involvement in the ratings process; the VA Schedule for Rating Disabilities; PTSD exams; and certification and specialization.

According to Dr. Steven Brown, Director of the Compensation and Pension Examination Program (CPEP), VHA receives approximately 400,000 exam requests per year from VBA and conducts almost double that number of exams, since many requests involve multiple body systems.² VHA performs exams at 135 locations nationwide and uses 57 exam templates. The national standard for requested exams to be completed and returned to the regional office is 35 days; meeting this turnaround time is the responsibility of the hospital-based physician-examiners.³

During town hall meetings, veterans complained about being called in for a second exam because the rater found the previous exam was conducted too long ago to still be viable. Further, panels of disabled soldiers told the Commission that waiting a month between the cessation of military pay and VA benefits was too long

² Brown, *CPEP Overview*.

³ Ibid.

The Commissioners who participated in the trip to San Antonio were impressed with the timeliness and quality of operations of the QTC site there (QTC is the private provider of government-outsourced occupational health and disability examination services). However, in Chicago, Boston, Atlanta, and Seattle, the Commissioners received unfavorable feedback about QTC's performance during discussions with staff from VBA, VHA, and VSO and with town hall participants.

V Vet Centers

Instituted in 1979, the Vet Centers provide readjustment counseling at 209 community-based locations nationwide. Readjustment counseling offers a wide range of services to all eras of combat veterans and their families to facilitate transition from military to civilian life. The Commissioners gathered information from Vet Center team leaders in Chicago, St. Louis, Seattle, Boston, and Atlanta. In three of those cities, roundtable discussions with veterans were held as well.

VI DoD

The Commissioners visited a military installation at each location. Although there was some variation among presentations by the Army, Navy, Air Force, and Marine Corps, they all briefed the Commissioners on their seamless transition activities surrounding classes in the Transition Assistance Program, Disabled Transition Assistance Program, Casualty Affairs, and the Disability Evaluation System.

The Commissioners also heard directly from service members who were in the process of transitioning back into the civilian sector. Their most commonly discussed issue was the need for VA compensation to begin during the month proceeding when their military pay ceases. Benefits Delivery at Discharge (BDD), which can expedite this process, was discussed at almost all locations. These service members also discussed their concerns about the medical and physical evaluation processes for rating disabilities.

In some locations, the Commissioners received briefings from the Army Community-Based Health Care Organization, which allows National Guardsmen and reservists to return to their homes of record while going through the medical board process. Panels of wounded, injured, and ill soldiers discussed their experiences with that process.

The Commission team was briefed on the Intrepid National Armed Forces Rehabilitation Center under construction at Brooke Army Medical Center in San Antonio. This unique venture, when completed, will provide severely injured

service members with state-of-the-art technology especially for amputees with advanced prosthetics, computerized and video monitoring, biomechanical studies, and advanced physical training therapy methods.⁴ Equally interesting was the VA/DoD collaboration program in Augusta, Georgia, that provides rehabilitation services to active duty personnel, families, and other caregivers.

VII Conclusions

The eight site visits gave the Commissioners a three-dimensional perspective on the issues surrounding services and benefits for disabled veterans, their dependents, and their survivors. These visits were invaluable to the Commission, and it extends its gratitude to everyone at VA and DoD who made the visits possible.

References

Brown, Steven. *CPEP Overview for the Veterans' Disability Benefits Commission* (presentation). Washington, DC: June 21, 2006.

Intrepid National Armed Forces Rehabilitation Center at the Brooke Army Medical Center, Fort Sam Houston, San Antonio, Texas.
<http://www.syska.com/Government/projects/intrepid.html>.

⁴ *Intrepid National Armed Forces Rehabilitation Center*, 2006.

Appendix E

Summary of Legal Analyses

Nearly a dozen legal issues pertinent to benefits for disabled veterans and their survivors were analyzed by Commission staff:

1. Character of discharge
2. Concurrent receipt of military retirement and VA disability compensation
3. Time limit to file claims for service-connected compensation
4. VA's duty to assist
5. Presumptions of service connection
6. Line of duty
7. Survivors' concurrent receipt of Survivor Benefit Plan (SBP) and dependency and indemnity compensation (DIC)
8. VA disability compensation apportionment and garnishment
9. VA compensation claims terminate upon the claimants' deaths
10. VA Vocational Rehabilitation and Employment Program (VR&E)
11. Age as a factor in evaluating service connection

1. Character of Discharge

An individual must be a veteran or the dependent or spouse of a veteran to be eligible for most benefits administered by the Department of Veterans Affairs (VA), including service-connected compensation and dependency and indemnity compensation. The statutory definition of a veteran is a person who served in active military service and was discharged there from "under conditions other than dishonorable" 38 U.S.C. 101(2) (2006).

Congress adopted this statutory definition in 1944 to establish a comprehensive standard governing basic eligibility for veterans' benefits based on the character of an individual's discharge or release from active military service. From the legislative history of the Readjustment Act of 1944, it is clear that Congress intended to liberalize the then existing requirement of a discharge under honorable conditions and correct what Congress viewed as an overly strict standard that unjustly prevented many who served faithfully, but were separated

for relatively minor offenses, from receiving veterans' benefits. At the same time, Congress recognized that a dishonorable discharge could only be given pursuant to a general court martial and that some individuals guilty of serious offenses were released without the formality of such a proceeding. In such cases, Congress was equally adamant that veterans' benefits should not be available.

Congress adopted the phrase "under other than dishonorable conditions" to accomplish its twin goals of liberalizing the standard for establishing basic eligibility for veterans' benefits while at the same time barring benefits to individuals separated for serious offenses. By adopting this phrase, Congress authorized VA to accept the characterization of a discharge or release by one of the uniformed services to the extent it is issued under clearly honorable or dishonorable conditions. It also provided VA with the authority and discretion to make its own character-of-discharge determinations for VA benefit purposes in those cases where the discharge or release is neither specifically honorable nor dishonorable.

In some instances, the statutory scheme authorizes VA to determine the character of a discharge for purposes of veterans' benefits. The scheme also continues the long-standing policy of permitting an individual with two periods of active service to receive benefits even if one of the periods of service was terminated by a dishonorable discharge, so long as the other period of service was terminated under conditions other than dishonorable. Congress reaffirmed this policy in 1977 when it amended 38 U.S.C. § 101 (2006)(18) to authorize eligibility for veterans' benefits to an individual who satisfactorily completes a period of service, but does not receive a discharge or release because of having agreed to extended active duty.

From the legal analysis completed for the Commission, it can be seen that the character of an individual's discharge or release from active military service is crucial to establishing eligibility for veterans' benefits. It is similarly evident that the primary elements of the scheme governing character-of-discharge determinations were established by Congress and have a long history. Finally, although the utility, the appropriateness, or even the wisdom of that statutory scheme has been questioned throughout the ensuing years, it continues to be applied as Congress intended.

2. Concurrent Receipt of Military Retirement Benefits and VA Disability Compensation

Some of the greatest congressional interest regarding veterans' disability benefits in recent years has been the debate over whether military retirees should be permitted to concurrently receive disability compensation from VA and military retired pay from the Department of Defense (DoD). Disabled military veterans have been granted disability compensation for service-connected

disabilities since colonial times. Congress first authorized military retirement pay in 1861 during the Civil War. As early as 1890, Congress expressly prohibited the concurrent receipt of both disability compensation and military retired pay.

Notwithstanding this long, consistent history, over the years proponents of concurrent receipt of disability compensation and military retired pay have sought to convince Congress to eliminate the prohibition. Proponents have generally argued that military retired pay and disability compensation are earned and awarded for distinctly different purposes. Military retired pay is earned compensation for services provided, and disability compensation is paid in recognition of the pain, suffering, and loss of earning capacity resulting from a service-connected disability. Arguing that the issue is a question of fairness, proponents claim that career military retirees are the only group of Federal retirees who are required to waive, or "offset," their retirement pay to receive disability compensation.

Opponents of concurrent receipt, usually point to the costs it would generate. The Congressional Budget Office (CBO) estimated in 2001 that the 10-year cost of totally eliminating the offset would be \$41 billion. Opponents of concurrent receipt also argue that eliminating the prohibition could lead to elimination of similar offsets that are common in other Federal programs. As to the alleged unfairness, opponents claim there is no unfairness in the lack of an analogous offset of disability compensation from other Federal retirement benefits because the military retirement system is unique.

Since the late 1990s, proponents of concurrent receipt have achieved some degree of success in convincing Congress to eliminate the prohibition. In 1999, Congress passed legislation providing partial concurrent receipt by awarding a special payment not subject to the offset provisions to severely disabled military retirees who were also receiving VA compensation. Congress enacted legislation in 2001 that authorized concurrent receipt but made it contingent upon passage of subsequent "qualifying offsetting legislation" that would fully offset the increased costs resulting from passage of the concurrent receipt legislation. No such "qualifying offsetting legislation," however, was enacted.

Congress created a new category of special compensation called "combat-related special compensation" in 2002. This legislation provided the financial equivalent of full concurrent receipt to some military retirees for certain defined combat-related disabilities. In 2003, Congress authorized the progressive implementation, over a 10-year period, of full concurrent receipt for military retirees with disabilities rated at least 50 percent disabling. At the same time, Congress expanded the scope of combat-related special compensation by eliminating the requirement that the disabilities resulting from the designated activities be rated at least 60 percent disabling.

In 2004, Congress eliminated the phase-in period for 100 percent disabled retirees making them eligible for full concurrent receipt effective January 1, 2005. Most recently, in 2006 Congress reduced the phase-in period from 10 years to 5 years for retirees rated 100 percent disabled by reason of a VA determination of individual unemployability.

Opponents of concurrent receipt challenge the claim that the prohibition against the practice unfairly discriminates against military retirees by requiring that only they, and no other Federal retirees, must reduce their retired pay in order to receive VA disability compensation. In this regard, opponents note that prior to the recent legislation modifying the prohibition, it had been in place for over 100 years, and during that period no member of the military had been promised concurrent receipt of both benefits. Moreover, opponents of concurrent receipt can rely on the decisions of the United States Court of Appeals in the *Absher* and *Howard* cases for the proposition that the circumstances of military retirees and other Federal civilian employees are very different. As the court noted in those cases, the special benefits accorded military retirees (e.g., commissary, recreational, travel, and health benefits as well as more liberal retirement criteria) provide a rational basis for concluding that the two groups of retirees are not similarly situated and that different provisions governing concurrent receipt of their retired pay are warranted.

The proponents of full concurrent receipt continue to advocate for elimination of all offsets. In the 109th Congress seven bills were introduced to eliminate all offsets: S. 13, S. 558, S. 845, H.R. 303, H.R. 2076, H.R. 2368, and H.R. 5881. None, however, abrogated the offset provisions.

3. Time Limit to File Claims for Service-Connected Compensation

The United States has a long history of providing generous assistance to veterans for disabilities resulting from injuries or diseases incurred during military service. With the exception of one period of time (1917–1930), veterans have never been required to file a claim for this assistance within a specified time frame or lose the opportunity to receive it. Currently, there is no time limit within which claims must be filed with VA for service-connected compensation benefits. Some commentators have suggested that the imposition of time limits for filing claims for such benefits may be reasonable. Others, however, have objected on the grounds that time limits are unwarranted and inconsistent with the intent and purpose upon which these benefits are based.

Notwithstanding that there are time limits for filing claims for many VA benefits, including insurance, education, and vocational rehabilitation benefits, traditionally, veterans and their survivors have had an unlimited period of time in which to file claims for VA compensation and dependency and indemnity

compensation (DIC). There was, however, one period during which this tradition was not maintained.

The years from 1917 through 1930 are the only period in our country's history in which veterans were required to file claims for service-connected compensation within specified time limits or lose the opportunity to do so. Despite this otherwise unbroken history, it has been recently suggested that the imposition of a time limit should be reconsidered and explored. Yet the mere suggestion that consideration be given to imposition of a time limit in which to file a claim has resulted in vigorous debate.

For example, in its December 1996 *Report to Congress*, the Veterans' Claims Adjudication Commission (VCAC) suggested, without attempting to resolve the issue, that establishing a delimiting date for claiming VA disability compensation warranted consideration. The VCAC was created by Congress to conduct a study of VA's system for adjudicating claims for veterans' benefits. Veterans' Benefits Improvements Act of 1994, Pub. L. No. 103-446, tit. IV, 108 Stat. 4645, 4659-63 (2006). In brief, the VCAC was charged with evaluating the efficiency of the then current VA adjudication processes and procedures and with developing recommendations and initiatives for increasing efficiency, reducing the number of pending claims, and enhancing the claims processing system.

In its discussion of the issue of establishing a delimiting date to file VA compensation claims, the VCAC recognized that traditionally veterans have had an unlimited period of time in which to file. *Report* at 266. The VCAC noted that although the generous filing privilege may be regarded as an advantage to veterans, it may also present disadvantages as well. *Id.* The VCAC listed and examined the advantages and disadvantages of a time limit in which to file claims. *Report* at 267-269.

The VCAC expressly stated that the purpose of its discussion of the advantages and disadvantages of establishing a delimiting date for VA disability claims was merely to explore the issue, not to resolve it. *Report* at 262. One commissioner, however, disagreed with the suggestion. On page 367 of the *Report*, Commissioner Chavez stated,
[EXT]

[t]his is a right which protects veterans' vital interests. I see no evidence of large numbers of such claims to justify any delimiting periods. TAP [Transition Assistance Program] and DTAP [Disabled Transition Assistance Program] counseling will over time reduce such claims. Conformity with other private or government programs may satisfy aesthetically, but offers no discernible benefit otherwise. There is no demonstrated need to reduce or remove unlimited time for filing original claims.

Commissioner Leach responded to the suggestion by adding 10 additional factors to the commission's list of disadvantages, and concluded by stating, [EXT]

[e]stablishment of a 5-year delimiting date will reduce the number of claims and provide reduction of work for adjudication division [sic], but it is obvious that it would deprive the veteran of benefits that were or may be promulgated into law after many years of experienced study. This could create hardship for many veterans and their dependents.

Report at 384-385

More recently, consideration of the issue of establishing a time period for filing VA compensation claims was raised before the Veterans' Disability Benefits Commission. Admiral Daniel L. Cooper, Under Secretary for Benefits for the Department of Veterans Affairs, suggested, <EXT>

[t]oday, there is no time limit for a veteran to submit an initial claim for disability compensation....I recommend this committee [sic] review and discuss this question.

Several veterans service organizations responded and presented their views on the issue to the Commission. In statements presented at the Commission's September 15, 2005, meeting, The American Legion, the Vietnam Veterans of America, the AMVETS, and the Military Coalition all expressed their opposition to imposition of a time limit. The Disabled American Veterans expressed its opposition in a letter dated August 10, 2005, from David W. Gorman, executive director of its Washington headquarters, to the Secretary of the VA. A copy of Director Gorman's letter was sent to the Commission.

4. VA's Duty to Assist

As early as the Revolutionary War, the United States Government demonstrated a commitment to assisting veterans. The concept of a Veterans' Administration, or what is now known as the Department of Veterans Affairs, did not become a reality until after World War I. Historically, VA has always assumed a policy of assisting claimants in marshalling evidence to substantiate their claims for VA benefits. The legislation governing the adjudication of veterans' benefits claims was intended to be nonadversarial, proclaimant, and veteran friendly. This philosophy culminated in the introduction and passage of two significant pieces of legislation that facilitate the development and full, fair evaluation of VA benefits claims:

1. The Veterans Judicial Review Act (VJRA) of 1988 (which created the statutory "duty to assist" veterans in developing their benefits claims)

2. The Veterans Claims Assistance Act (VCAA) of 2000

Prior to these two major legislative actions, there were previous administrative practices and procedures as well as regulatory provisions that defined the “duty to assist” within VA. There have also been several court decisions that addressed the plausibility of a claim to a fair and impartial adjudicator (i.e., “well-groundedness”) and its relationship to the duty-to-assist requirements. The Commission’s legal analysis of this issue explored significant case law relating to the duty-to-assist requirement, paramount among them being the 1999 *Morton* decision, which reaffirmed the “well-grounded” claim prerequisite for the activation of the “duty to assist” in adjudication of VA benefits claims and ultimately led to enactment of the VCAA.

The Veterans Judicial Review Act (VJRA) ended more than a century of congressional measures that precluded adjudication of veterans' benefits claims in the appellate court system. 38 U.S.C. § 7251 (2006). Prior to this new law, any decision made by VA about a veteran's claim was deemed final, and there was no recourse for independent judicial review of an appeal. The legislation created the statutory “duty to assist,” modified the existing Board of Veterans Appeals (BVA) to enhance its independence from VA, and established a Court of Veterans Appeals (CVA), which later became the Court of Appeals for Veterans Claims (CAVC), with jurisdiction to review BVA decisions. The VJRA also allows attorneys to represent veterans before the CVA and receive more appropriate remuneration.

Another pivotal development in the VA’s adjudication process for veterans’ claims was the passage of the Veterans Claims Assistance Act of 2000 (VCAA). 38 U.S.C. § 7251 (2006). This act restored and enhanced VA's duty to assist (previously abrogated in the *Morton* decision in 1999) claimants in developing their claims for veterans benefits. The VCAA requires VA to take very specific, clearly delineated steps to assist claimants. Although VA was already required to notify a claimant whose application was incomplete, under the VCAA, VA must now also inform a claimant of any medical or lay evidence necessary to substantiate his or her claim. The VCAA also specified that this notice must indicate what proportion and type of corroborating evidence is to be provided by the claimant and which portion VA will attempt to obtain on behalf of the claimant.

5. Presumptions of Service Connection

A presumption may be most simply viewed as a conclusion or inference drawn from the existence of some fact or group of facts. In the context of the adjudication of VA compensation claims, a somewhat more precise and legalistic view is that a presumption relieves a VA claimant of the burden of producing evidence that directly establishes one or more facts that would otherwise be

necessary to substantiate the claim. For example, in the case of a veteran claiming disability compensation, if the evidence shows manifestation of a disease covered by a presumption of service connection within the specified period, then service connection may be established (so long as the veteran currently suffers from that same disease at the time that the claim is filed). In such a case, service connection is established even though there is no medical evidence of an actual connection between the disease and the veteran's military service. The effect of the presumption is to shift the burden to the Government to prove that there is no connection between the disease and service.

There are several reasons that justify the widespread use of presumptions in the adjudication of VA benefit claims. Presumptions may simplify and streamline the adjudication process by eliminating the need to obtain evidence and decide complex issues. Presumptions also promote accuracy and consistency in adjudications by requiring similar treatment in similar cases. Presumptions may relieve claimants and the VA of the necessity of producing direct evidence when it is impractical or unduly burdensome to do so. Finally, presumptions may implement policy judgments that the burdens arising in certain cases be borne by the Government rather than the veteran claimants notwithstanding the uncertainty surrounding the issue of whether the claimants' disabilities were, in fact, incurred or aggravated by service.

As noted, presumptions are used throughout the process of adjudicating claims for various VA benefits. Their use occurs most extensively, however, in meeting a key requirement necessary to substantiate a claim for VA compensation benefits, meaning establishing service connection, the showing of a connection between military service and incurrence or aggravation of a veteran's disease or injury. In claims for VA compensation benefits, veterans generally bear the burden of proving their disabilities result from diseases or injuries that were incurred in or aggravated by military service. This burden is generally met by producing evidence the disease or injury occurred coincident to the military service. Once the evidence establishes that a presumption of service connection applies, however, the veteran is relieved of the burden of proving service incurrence or aggravation. In such a claim, unless there is affirmative evidence showing that the disease or disability was not incurred in or aggravated by service, VA must grant service connection.

In many, if not most, claims, it is relatively simple for veterans to meet the burden of proving their disabilities are service connected. The veteran's military records may clearly describe and document the circumstances and medical treatment for an injury or an illness suffered while in service as well as any resulting disability. In such a claim, the veteran's burden of proving service connection is easily met.

In other claims, however, where the manifestation of the disability is remote from the veteran's service and any relation between the disability and service is not readily apparent, the burden of proving service connection can be daunting. The

difficulties that can arise in proving service connection were recognized very early. In 1921, Congress first enacted a presumption of service connection for specific diseases to assist veterans in meeting the difficult burden they faced when attempting to establish a connection between their military service and the development of disabilities resulting from such diseases. Act of August 9, 1921, ch. 57, § 18, 42 Stat. 147. That act provided that pulmonary tuberculosis or neuropsychiatric disease developing to a degree of 10 percent or more within 2 years after service would be considered to have been incurred in, or aggravated by, service. Since that time, the application of presumptions within VA has been greatly expanded to encompass, among others, World War II and Korean War veterans, former prisoners of war (POW), and Vietnam and Persian Gulf theater veterans who incurred injuries or illnesses due to exposure to either mustard gas, ionizing radiation, or agent orange, among other precipitants or irritants.

6. Line of Duty

The "line of duty" requirement has been included in one form or another in the statutory provisions governing entitlement to service-connected disability and death benefits since the beginning of the Federal Government. Throughout much of this period, the appropriate interpretation to be accorded to the phrase was a matter of constant debate, uncertainty, and confusion. The phrase has been the subject of numerous administrative opinions by a variety of executive departments as well as conflicting judicial decisions. The discussion in each instance centered primarily on whether, for benefit entitlement purposes, the phrase required a causal connection between the performance of military duty and the disease contracted or the injury incurred in service that resulted in disability or death, or was it sufficient merely that the disease or injury occurred coincident with military service.

For purposes of service-connected disability and death benefits currently administered by VA, the question has been resolved by statute, 38 U.S.C. § 105 (2006). Under section 105, a veteran is entitled to compensation, for example, for any disability resulting from injury incurred or disease contracted during a period of active military service unless such injury or disease is the result of the veteran's own willful misconduct or abuse of alcohol or drugs. Compensation will also be barred if, when the injury is incurred or the disease is contracted, the veteran is deserting or absent without leave or confined under sentence of a court martial or a civil court for commission of a felony. Although much ambiguity and confusion has been eliminated under the provisions of the present statutory definition found in section 105, the debate as to whether a causal connection between the disability or death and the performance of military duty *should be required* continues.

Evidence of the debate's ongoing nature, aside from the fact that the issue is being addressed by the present Commission, is found in the testimony of the

General Accounting Office (GAO) dated September 23, 2003, prepared for the United States Senate Committee on Veterans' Affairs. U.S. General Accounting Office, *VA Benefits: Fundamental Changes to VA's Disability Criteria Need Careful Consideration*, GAO-03-11727T (Washington, DC: September 23, 2003). In the testimony, GAO stated that in March 2003, the Congressional Budget Office (CBO) reported that veterans received about \$970 million in VA compensation in fiscal year 2002 for diseases GAO identified as neither caused nor aggravated by military service. Moreover, CBO estimated that VA could have saved \$449 million in fiscal years 2004–2008 if compensation payments to veterans with several previously service-connected, disease-related disabilities were eliminated in future cases. GAO also noted its earlier report, U.S. General Accounting Office, *VA Benefits: Law Allows Compensation for Disabilities Unrelated to Military Service*, GAO/HRD089-60 (1989), and reiterated its suggestion therein that Congress might wish to reconsider whether diseases not caused or aggravated by performance of military duties (“line of duty”) should be compensated as service-connected disabilities.

7. Survivors' Concurrent Receipt of Survivor Benefit Plan and Dependency and Indemnity Compensation

Among the issues facing Congress recently has been the benefits for military survivors, especially those of service members killed during the war on terrorism in Afghanistan and Iraq. A key aspect of this issue is the current provisions that prevent the concurrent receipt of full benefits payable under the DoD Survivor Benefit Plan (SBP) and the VA dependency and indemnity compensation (DIC) programs that are intended to sustain military survivors in the long term. Several veterans service organizations have asserted that concurrent receipt (without an “offset,” or adjustment in amount of another benefit received by the same beneficiary) of these benefits is imperative to the financial viability of both the survivors of service members killed on active duty and the survivors of retirees who die of a service-connected cause. The current “offset” provisions of these survivor benefits programs have thus become a source of contentious debate.

Benefits for survivors of deceased members of the armed forces vary significantly in purpose and structure. Benefits such as the death gratuity provide immediate cash payments to assist these survivors in meeting their financial needs during the period immediately following a member's death. Similarly, the Servicemembers' Group Life Insurance (SGLI) provides the policy value in a lump sum payment following the service member's death. The DIC and SBP are designed to provide long-term monthly income. Additional death benefits provided to survivors and dependents include housing assistance, health care, commissary and exchange benefits, educational assistance, and burial, funeral, and related benefits. Survivors may also receive death benefits from Social Security.

The Defense Authorization Act of 2002 authorized SBP eligibility for survivors of all members who die on active duty. Pub. L. No. 107-107. The legislation provided that the SBP annuity is to be calculated as if the member was disability retired with a 100 percent disability on the date of death. Previously, survivors of members who died on active duty were not eligible unless the member had at least 20 years of service. Pub. L. No.107-107 § 642.

Congress has considered the offset issue over the years. An attempt at policy reform in the 109th Congress to repeal the “offset” provisions occurred with the advent of parallel legislation introduced in the House (H.R. 808) and in the Senate (S. 185). However, the John Warner National Defense Authorization Act for Fiscal Year 2007, signed by President Bush on October 17, 2006, retained the offset for at least the immediate future.

8. VA Disability Compensation Apportionment and Garnishment

VA compensation can only be garnished to pay child support when a former member of the Armed Forces, who has waived all or a portion of military retired or retainer pay in order to receive the compensation, and then only the amount of VA compensation that represents the military retired pay or retainer pay that has been waived is subject to garnishment for child support.

By statutory authority, military retired pay and retainer pay is subject to garnishment for child support. See 42 U.S.C. § 659(h)(1)(A)(II)(2006). Section 5304, of title 38, United States Code, prohibits a retiree from receiving retired pay and compensation at the same time. Because military retirees are required to waive their military retired pay in order to receive VA compensation, this cannot be shelter from the garnishment that would otherwise occur. Therefore, VA compensation can be garnished pursuant to a court order to pay child support or alimony, but only when a veteran receives the compensation in lieu of military retired pay with a partial or total waiver. See 42 U.S.C. § 659(h)(1)(A)(V)(2006) and 5 C.F.R. 581.103(c)(7)(2006). Disability compensation is the only VA benefit subject to garnishment for child support. See 42 U.S.C. § 659(h)(1)(B)(iii)(2006) and 5 C.F.R § 581.104(b)(2006).

When a garnishment order is received by a VA regional office, it is referred to the district counsel. The district counsel is responsible for reviewing the order and preparing a memorandum explaining the legal basis for any further action and the amount of the garnishment that is to be established. The memorandum is forwarded to adjudication, where an award withholding the garnishment amount is processed. Garnishment of VA compensation is not subject to the advance notice required for other types of benefit reductions and can be implemented upon receipt. See 38 C.F.R. 3.103(b)(3)(vi)(2006). The veteran may appeal to

the Board of Veterans' Appeals only those issues involving VA's implementation mechanics. The provisions or inherent legality of the garnishment order are under the jurisdiction of the issuing court.

The Defense Authorization Acts of 2003 and 2004 created combat-related special compensation (CRSC) and concurrent retirement disability payments (CRDP), and the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005 eliminated the phase-in period for CRDP for retirees who are receiving 100 percent VA compensation. The effect of CRSC and CRDP on the garnishment of VA compensation is currently under review.

Apportionment

An apportionment refers to a distribution or allotment of a benefit. VA benefits can be apportioned between a veteran and his or her dependents (but not garnished unless received in lieu of military retirement). For an apportionment to be considered by VA, a claimant must make an application, and the evidence submitted must meet VA's requirements. Unlike cases of garnishment where there has been a court order, in apportionment cases VA must follow regulations to ensure due process in making a determination of a claim. Veterans are kept informed of all allegations, and both parties are asked to furnish statements of net worth, annual income, and expenses. Apportionments are not made by VA when it would cause undue hardship to the veteran, if there are other resources available for the spouse, or if the spouse has been found guilty of conjugal infidelity or is publicly known as someone else's spouse. Former spouses are not entitled to apportionments. Apportionments are made when a veteran is not reasonably contributing to a child or to children not living with the veteran. Veterans' benefits can also be apportioned in cases where there is a dependent parent or if the veteran is incompetent, has disappeared, is incarcerated, or has forfeited his or her benefits. In 1998, the VA acting general counsel reported that, "There are currently nearly 23,000 cases in which running awards of VA benefits of all kinds are being apportioned to spouses for children." As of June 2007, there were 1,569 cases involving survivors and 15,080 with veterans and dependents.

An apportionment of a veteran's benefit can only be made when a complete claim and evidence is received by VA. 38 C.F.R. §§ 3.450-3.458 (2006) regulates how award actions should be handled, such as effective dates, adjustments, development and due process, and notification to veteran and apportionment claimant. According to the acting general counsel, "The unavailability of garnishment in most cases with respect to VA benefits is relieved somewhat by the availability of administrative apportionment." Apportionments are made to the veteran's spouse, if he or she is not living with the veteran, or to the veteran's children, if they are not in the custody of the veteran.

There are a number of factors that must be considered when determining whether and to what extent to apportion a veteran's benefits. For example, a veteran's benefits may be apportioned when the veteran is not reasonably discharging his or her responsibility for the spouse's or children's support. This stipulation ensures that only those veterans who are not meeting their parental or spousal responsibilities are subjected to apportionment. Also, VA gives consideration to whether the apportionment would cause an undue hardship for the veteran. Based on this concern, the amount of benefits the veteran receives, the veteran's resources compared to the dependent's resources, and the special needs of the veteran and dependents are all considered. Obviously, such stipulations and considerations will vary in each case, making apportionment cases unique.

Because these reviews take place at all of the regional offices across the country, variances in the decision-making process may occur. A centralized location that handles all of the apportionment claims could be possible. The Commission has seen examples of such VA practices when it conducted site visits and heard testimony on the efficiency of centralizing benefits delivery at discharge cases at two locations. The Commission is also aware that VA centralizes insurance cases at a single location in Philadelphia, education claims at four locations, pension claims at three locations, loan guaranty at nine locations, and all overseas cases are handled in Pittsburgh. Centralization of apportionment decisions might allay concerns that there are variations in apportionment decisions by VA.

9. VA Compensation Claims Terminate Upon the Claimants' Deaths

Under the statutory scheme governing service-connected disability compensation benefits administered by VA, a veteran's claim for compensation, which is pending at the time of the veteran's death, is terminated because only veterans can receive compensation. Benefits owed to a veteran but unpaid are available to survivors or the veteran's estate as accrued benefits. The one exception to this rule is provided in the procedure governing the filing of a claim for accrued benefits. The accrued benefits procedure, however, is limited in that it permits certain survivors to recover only benefits to which the entitlement has already been established or can be readily established based on evidence in the file at the date of the veteran's death, and that are as yet unpaid. In addition, applications for accrued benefits must be submitted within 1 year after the veteran's death.

The courts, interpreting the overall statutory scheme governing compensation, dependency and indemnity compensation (DIC), and accrued benefits, have consistently held that a pending claim for compensation terminates upon the claimant's death. Some veterans' advocates, however, have argued that the

statutory provisions are unfair and should be amended to permit the continuation of not only a pending VA compensation claim, but a claim for other VA benefits as well, and allow a claimant's survivors or estate to receive the full benefits that would have been paid if the claimant had survived.

The United States Court of Appeals for the Federal Circuit and the United States Court of Appeals for Veterans Claims (CAVC) have reviewed the issue of whether a veteran's pending claim for VA compensation survives the veteran's death on several occasions. In their decisions, the court has described the statutory scheme, explained how the structure and language of the scheme manifest an intent to terminate a veteran's claim to disability compensation at death, and have consistently ruled that, based upon the overall statutory scheme, such claims do not survive the veteran's death.

In *Landicho v. Brown*, 7 Vet. App. 42, 47 (1994), the CAVC, then the Court of Veterans Appeals, first discussed the overall statutory scheme governing disability compensation, and concluded that veterans' pending claims for compensation under that scheme do not survive their deaths. In this regard, the CAVC noted that veterans' and survivors' benefits are, for the most part, provided in title 38 of the United States Code. Further, the court stated that while chapter 11 of title 38 provides for disability compensation, it makes no provisions for survivors. Instead, chapter 13 of title 38 provides DIC benefits to specified survivors of veterans whose deaths are service-connected or who have been rated 100 percent for service-connected disabilities for a required period immediately before death. Moreover, the scheme specifically provides in 38 U.S.C. § 5112(b)(1)(2006) for termination of disability compensation by reason of the veteran's death to occur on the last day of the month before the death, and in 38 U.S.C. § 5110(d)(2006) for DIC benefits to begin, when the DIC application is received within 1 year of the veteran's death, on the first day of the month in which the death occurred. In the CAVC's view this overall statutory scheme created "a chapter 11 disability compensation benefit that does not survive the eligible veteran's death." *Id.*

The court also briefly noted the one exception to the rule that a veteran's claim for disability compensation does not survive the veteran's death contained in the accrued benefit procedures provided in 38 U.S.C. § 5121(2006). In this regard, citing 38 U.S.C. § 5121(a) and (c)(2006), the court stated that in the accrued benefit provisions, "Congress has set forth a procedure for a qualified survivor to carry on, to the limited extent provided for therein, a deceased veteran's claim for VA benefits by submitting an application for accrued benefits within 1 year after the veteran's death." *Id.*

The Court of Appeals for the Federal Circuit in *Haines v. West*, 154 F. 3d 1298, 1300 (Fed. Cir. 1998), *cert. denied*, 526 U.S. 1016 (1999), analyzed the same statutory provisions and reached the same conclusion. The *Haines* court also discussed the accrued benefit provisions found in 38 U.S.C. § 5121(2006). The

court explained the limited nature of the accrued benefits exception noting that a survivor may only seek payment of those benefits that were due and unpaid at the time of the veteran's death. The court observed that the statute, as then written, limited payment to those benefits that were due and unpaid for a period not to exceed 2 years prior to the veteran's death. According to the court, the accrued benefits provision "thus creates a narrowly limited exception to the general rule that a veteran's claim for benefits does not survive the veteran." *Id.*

The Federal Circuit again addressed the issue in *Richard v. West*, 161 F. 3d 719 (Fed. Cir. 1998). In *Richard*, a veteran died while his appeal of VA's denial of his claim for service-connected disability compensation was pending in the Court of Veterans Appeals. The deceased veteran's brother, on behalf of the veteran's estate, sought to have himself substituted as a party to continue the appeal. The brother's principal argument was that the silence of the statutory scheme concerning disability payments to survivors and the lower court's procedural rules expressly allowing substitution compel the conclusion that the veteran's estate may be substituted for the veteran in a pending appeal. According to the brother, a conclusion that sections 5121 and 5112 were intended to prevent heirs of a deceased veteran from pursuing pending appeals because chapter 11 is silent regarding survivorship would contravene the broad remedial purposes of the statute. *Id.* at 721-722.

The court disagreed, however, stating that the brother's statutory argument could not overcome "the clear intent expressed by the structure and language of the statutory scheme at issue—that a veteran's claim to disability benefits terminates at death." *Id.* After reiterating the analysis of the statutory scheme as stated in its earlier *Haines* decision, the court reaffirmed that analysis and noted that the brother's argument would both swallow the narrowly limited exception of section 5121 and render section 5112(b)'s express termination of the payment of disability compensation virtually meaningless. *Id.*

In reaching its decision, the court in *Richard* also briefly discussed the legislative history of the accrued benefits procedure eventually codified at 38 U.S.C. § 5121 (2006). According to the court, instead of providing for the payment of disability compensation to survivors, "Congress in 1943 established a procedure whereby a limited amount of 'accrued benefits' due to the deceased veteran could be recovered by designated individuals. Act of July 13, 1943, ch. 233, Pub. L. No. 78-144, 57 Stat. 554, 557. *Id.* at 721. The court later observed that nothing in the legislative history persuaded it to change the results it reached in *Haines*. Although the court stated that it considered the legislative history to be inconclusive to its inquiry, it did note that it demonstrates "a record that broadly reflects a transition from express prohibitions of payments to veterans' estates to explicit allowance of payments to certain individuals. See, e.g., H.R. Rep. No. 78-463, at 14 (1943); S. Rep. No. 78-403, at 11 (1943). *Id.* at 722-723.

One final argument that the court addressed in *Richard* was the brother's claim that any construction of the statutory scheme that reaches the conclusion that a deceased veteran's compensation claim terminates at death would violate the constitutional requirement of procedural due process. *Id.* In response, the court noted that to raise a due process challenge, a claimant must have a property interest entitled to due process protection. In this instance, because a veteran's entitlement to disability compensation is terminated at death, a veteran, and therefore a veteran's estate, cannot have a protected property interest in such compensation. The court cited *Lyng v. Payne*, 476 U.S. 926, (1985) for the proposition that the Supreme Court has never held that applicants for benefits, as opposed to benefits recipients, have a legitimate claim of entitlement protected by the due process clause of the fifth or the fourteenth amendment.

As the Federal Circuit observed, the provisions of 38 U.S.C. § 5121(2006) are not identical to the provisions of the 1943 statute that established the accrued benefits scheme. The court in *Richard* characterized the changes that had occurred in the scheme until that point in time as minor. *Richard*, 161 F. 3d at 723. However, in 2003, Congress enacted a substantial change to the accrued benefits scheme.

Prior to enactment of the Veterans' Benefits Act of 2003, Pub. L. No. 108-183 § 104(a), section 5121(a) provided that VA monetary benefits, including disability compensation, due and unpaid at a claimant's death for, at most, 2 years were payable to the claimant's eligible survivors. The act amended section 5121(a) to remove the 2-year limitation period on a survivor's recovery of such accrued benefits. In doing so, Congress repealed a major feature of the 1943 accrued benefits scheme, and, instead of limiting the amount of accrued benefits payable, provided survivors with the opportunity to receive the full amount of benefits that would have been paid if the veteran had survived.

Some have criticized the statutory scheme under which a veteran's claim for VA disability compensation that is pending at the time of the veteran's death is terminated. One such critic, Congressman Lane Evans, introduced H.R. 3733 in the 107th Congress and H.R. 1681 in the 108th Congress, both titled the "Veterans Claims Continuation Act," a bill "[t]o amend title 38, United States Code, to allow for substitution of parties in the case of a claim for benefits provided by the Department of Veterans Affairs when the applicant for such benefits dies while the claim is pending."

Former Congressman Evans discussed H.R. 3733 in a statement in the *Congressional Record*. 148 Cong. Rec. E176 (daily ed. Feb. 15, 2002) (statement of Rep. Evans). The congressman called H.R. 3733 an important measure that would allow families of veterans to continue claims for benefits that are pending at the time of a veteran's death and assure that they receive the full benefits that would have been paid, if the veteran had survived. He cited the decision of the United States Court of Appeals for Veterans' Claims in *Marlow v.*

West, 12 Vet. App. 548 (1999), as a particularly egregious case demonstrating the need for a change in the accrued benefits law.

The congressman noted that due to the backlog of cases pending in VA, it is inevitable that some claimants will die while their claims are pending. Further, he stated that many veterans' families have incurred substantial expenses and suffered financial hardship while claims were pending. If benefits are justified, these families should be made whole. He also stated that older veterans have expressed concern that VA uses delaying tactics, hoping the veteran will die before the claim is allowed. Although he stated he had no evidence that VA was using such tactics, the congressman observed that the inability of family members to continue claims and the 2-year limitation on any accrued benefits payable then in the law may erroneously give veterans this impression. Congressman Evans noted that other government benefits, such as Social Security benefits, are not extinguished when a claimant dies, and that the families of veterans deserve no lesser rights than Social Security claimants.

In a letter dated November 4, 2003, to the chairman of the Committee on Veterans Affairs, United States House of Representatives, then Secretary of Veterans Affairs Anthony J. Principi expressed VA's opposition to H.R. 1681, 108th Congress. In the letter, the Secretary stated:

VA opposes this legislation primarily because it would represent a significant departure from established principles governing provision of veterans benefits. Traditionally, VA monetary benefits have been provided to meet subsistence needs of veterans and their dependents and survivors. By making such benefits subject to claim by the veteran's estate, the benefits would be transformed into property to be inherited by estate beneficiaries or claimed by creditors. Further, benefits could pass from the estate to individuals who had little or no contact with the veteran. We do not believe the limited funds available for payment of veterans benefits should be expended in this manner.

VA also claimed that the legislation would impose significant additional burdens on VA. Unlike under the current provisions of 38 U.S.C. § 5121 (2006), H.R. 1681 would require VA to undertake substantial evidentiary development on the claim after the veteran's death when the veteran would not be available to provide the critical information and assistance necessary to such development. According to VA, because of the nature of the evidence to be developed to properly adjudicate claims for disability compensation and obligations imposed on VA under the Veterans Claims Assistance Act, it may be impossible for VA to obtain the information necessary to resolve such claims. VA estimated that enactment of H.R. 1681 would result in mandatory benefit costs of \$18.8 million for the first year, \$47.4 million over 5 years, and \$65.4 million over 10 years.

Enactment would also result in discretionary administrative costs of \$750,000 in the first year, \$2.9 million over 5 years, and \$5.4 million over 10 years.

Legislation similar to H.R. 1681 has not been reintroduced in Congress to date.

10. VA Vocational Rehabilitation and Employment Program

The Vocational Rehabilitation and Employment (VR&E) Program is authorized by Congress under 38 U.S.C. § 31 (2006). The mission of VR&E is to help veterans with service-connected disabilities to prepare for, find, and maintain suitable jobs. For veterans with service-connected disabilities so severe that they cannot immediately consider work, VR&E offers services to improve their ability to live as independently as possible.

VR&E is a long-standing compensatory benefit for disabled military veterans. Since its inception during World War I under the War Risk Insurance Act, its mission has been to provide empirically validated, cost-effective vocational rehabilitation services and educational benefits to veterans with service-connected disabilities as well as to dependents, and, in some cases, nonservice-connected veterans (such as those engaged in VA's Transition Assistance Program and Disabled Transition Assistance Program (TAP/DTAP) authorized under Public Law 101-237 and Public Law 101-510.) A long line of legislation elucidates the processes that were conceived and implemented to facilitate a "seamless transition" from military service to successful rehabilitation and suitable employment. Persistent criticism, as noted by the 2004 VR&E Task Force, has been leveled against VR&E since its inception regarding its lack of efficacy, efficiency, and accountability. In a previous task force in the late 1970s, an attempt was also made to address these problems. It culminated in the creation of the current iteration of VA's VR&E Program through the enactment of the Veterans' Rehabilitation and Education Amendments of 1980 (Pub. L. No. 96-466).

Repeated efforts at reform through the years have met with varying degrees of success. Since the inception of the major 1980 reforms, VR&E has been significantly affected by statutory changes, such as Public Law 101-508, which in 1990 eliminated entitlement for veterans with a 10 percent service-connected disability. Then, in 1993, Public Law 102-568 changed the law again so that veterans with a 10 percent service-connected disability were once again entitled to benefits. In 1996, Public Law 104-275 defined and provided for "limited rehabilitation" as participation in self-employment and the completion of training for homebound veterans with severe service-connected disabilities to achieve vocational rehabilitation. On January 10, 2000, VR&C officially became known as VR&E to emphasize its focus on finding and maintaining suitable employment for rehabilitated veterans.

More recently, VA has attempted to address the vocational and employment reintegration needs of returning Operation Iraqi Freedom/Operation Enduring Freedom (OEF/OIF) service members is the Coming Home to Work initiative (CHTW). Through this initiative, unpaid work experience in a government facility is made available to VR&E-eligible service members pending medical separation from active duty at military treatment facilities. Participants work directly with a VR&E vocational rehabilitation counselor to obtain volunteer or work experience in a government facility that supports their career goals. The CHTW initiative provides valuable civilian job skills, exposure to opportunities, and work experience history to service members facing medical separation from the military and uncertain futures. VA is also facilitating successful reintegration via priority processing of OEF/OIF service member applications, and an ongoing alliance to facilitate job development and placement activities with the Department of Labor Veterans Employment and Training Service (DOL-VETS).

11. Age as a Factor in Evaluating Service Connection

Under current law, VA assigns evaluations of service-connected disabilities pursuant to authority contained in 38 U.S.C. § 1155 (2006). This section provides for a schedule of ratings of reduction in earning capacity resulting from specific injuries or combinations of injuries. Under section 1155, ratings are to be based, so far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations.

The Commission's research regarding this issue did not reveal any past or present statutory provisions concerning age as a factor in evaluating service connection. However, in the Schedule for Rating Disabilities currently used by VA under authority of section 1155, age is not a factor in the assignment of a service-connected disability evaluation. In this regard, VA regulation 38 C.F.R. § 4.19 (2006) specifically provides as follows:

§ 4.19 Age in service-connected claims.

Age may not be considered as a factor in evaluating service-connected disability; and unemployability, in service-connected claims, associated with advancing age or intercurrent disability, may not be used as a basis for a total disability rating. Age, as such, is a factor only in evaluations of disability not resulting from service, i.e., for the purposes of pension.

The regulatory history of VA's Schedule for Rating Disabilities shows that it included a version of section 4.19 substantially identical to its current provisions when the Schedule was added as part 4 of chapter I to title 38 of the Code of Federal Regulations on May 22, 1964. 29 Fed. Reg. 6,718 (2006). The preamble to the 1964 regulatory action explained only that the Schedule was

being added to title 38 of the Code of Federal Regulations and that it was commonly referred to as the 1945 Rating Schedule, which had become effective April 1, 1946. *Id.*

**Appendix
F**

**Executive Summary of The CNA Corporation's
Final Report to the Commission:**

Compensation, Survey Results, and Selected Topics

Executive summary

The Veterans' Disability Benefits Commission (the Commission) asked The CNA Corporation (CNAC) to help assess the appropriateness of the benefits that the Department of Veterans Affairs (VA) provides to veterans and their survivors for disabilities and deaths attributable to military service.¹ Specifically, the Commission is examining the standards for determining whether a disability or death of a veteran should be compensated and the appropriateness of benefit levels. The overall focus of this project is to provide analyses to the Commission regarding the appropriateness of the current benefits program for compensating for loss of average earnings and degradation of quality of life resulting from service-connected disabilities for veterans. We also evaluated the impact of VA compensation for the economic well-being of survivors and assessed the quality of life of both service-disabled veterans and survivors.

Although we explored other issues for the Commission and documented those results elsewhere (e.g., [1]), the primary focus of this report is to address the above issues. In addition, we provide a summary of selected additional topics that the Commission asked us to address:

- Disincentives for disabled veterans to work or to receive recommended treatment or therapy.
- Surveys of raters and Veterans Service Officers with regard to how they perceive the processes of rating claims and assisting applicants.
- Comparing the VA disability compensation program to other disability programs
- Evaluating the option of offering a lump sum alternative to some service-disabled veterans.
- Individual unemployability (IU), mortality, and Social Security Disability Income (SSDI)
- Comparing DOD disability determinations to those conducted by the VA.

We also discuss options that the Commission may want to consider, along with data recommendations that would improve the quality of future evaluations.

1. We also evaluated DOD disability separation ratings in comparison to VA ratings.

Earnings comparisons for service-disabled veterans

Our primary task was to answer the question of how well the VA compensation benefits serve to replace the average loss in earnings capacity for service-disabled veterans. Our approach identified target populations of service-disabled veterans and peer or comparison groups (non-service-disabled veterans) and obtained data to measure earned income for each group. We also investigated how various factors such as disability rating, type of disability, and age impact earned income. Finally, we compared lifetime earned income losses for service-disabled veterans to their lifetime VA compensation, adjusting for expected mortality and discounting to present value terms, to see how well VA compensation replaces lost earning capacity.

Congressional language indicates that the intent of VA compensation is to provide a replacement for the average impairment in earning capacity. The VA compensation program is not an individual means-tested program, although there are minor exceptions to this. Therefore, we focused on average losses, first for all service-disabled veterans and then for subgroups. We defined the subgroups of disabled veterans, through consultation with the Commission, on the body system of the primary disability (16 in all) and on the total combined disability rating (10 percent, 20-40 percent, 50-90 percent, and 100 percent disabled). In addition, we further split the 50-90-percent disabled group into those with and without individual unemployability status (IU). After meeting certain disability criteria as well as providing evidence that they are unable to engage in substantial gainful employment, IU disabled veterans receive compensation at the 100-percent disabled level. Finally, we evaluated three subgroups of veterans who received certain types of special medical compensation (SMC).

To make earnings comparisons over a lifetime, it is necessary to have a starting point. In other words, a young service-disabled veteran will have a long period of lost earnings capacity during prime wage-earning years, while a veteran who enters into the VA disability compensation system at an older age will face reduced earnings capacity for a smaller number of years. If a veteran first becomes eligible for VA compensation at age 65 or older, the average expectation of lost earnings is very low, because a large share of individuals are retired or planning to retire soon by this age. The data show that the average age of entry into the VA compensation system is about 55 years, although many enter at a younger or older age. Also, the average age of entry varies somewhat across the body systems of the primary disability and combined degree of disability.

Looking at average VA compensation for all male service-disabled veterans, we find that they are about at parity with respect to lost earnings capacity at the average age of entry. Looking across all service-disabled veterans, at an age of entry of 55, we find that by comparing the discounted present value of their lifetime expected earnings to the earnings of their peer group (i.e., veterans who were not service disabled), the average earned

income loss was \$163,519. For all service-disabled veterans, we estimated the lifetime present value of their average VA compensation to be \$148,580. These two figures are very similar. To calculate expected earnings parity, we take the ratio of service-disabled earned income plus VA compensation (\$416,693) divided by the present value of total expected earnings for the peer group (\$431,637). This figure is 0.97, which is very close to parity.² A ratio of exactly 1 would be perfect parity, indicating that the earnings of disabled veterans, plus their VA compensation, gives them the same lifetime earnings as their peers. A ratio of less than one would mean that the service-disabled veterans receive less than their peers on average, while a ratio of greater than one would mean that they receive more than their peers.

We also evaluated the parity of earned income and VA compensation for service-disabled veterans compared to the peer group by disability rating group and age at first entry into the VA compensation system. Our findings indicate that it is important to distinguish whether the primary disability is a physical or a mental condition. We found that there is not much difference in the results among physical body systems (e.g., musculoskeletal, cardiovascular), and for mental disabilities, it does not matter much whether the disability is for PTSD or some other mental disability.

If we only look at those with a physical primary disability, our findings indicate that service-disabled veterans are generally at parity at the average age of first entry into VA compensation system (50 to 55 years of age). This is true for each of the rating groups. However, we observed earnings ratios substantially below parity for service-disabled veterans who were IU, and slightly below parity for those who were 100-percent disabled, who entered at a young age (age 45 or less). Those who first entered at age 65 or older were above parity, except for the 10-percent disabled subgroup, which was essentially at parity. Table 1 shows the details for the subgroups for those with a primary physical disability.

2. For female veterans, the comparable figure is 1.01. In general, we report results for female veterans in an appendix, because our data have far fewer female than male veterans.

Table 1. Earnings ratio by rating group and age at first entry for those with a physical primary disability (men)^a

Age at first entry	10%	20-40%	50-90% not IU	IU	100%
25	0.99	1.02	1.10	0.75	0.94
35	0.99	1.02	1.08	0.71	0.89
45	0.96	0.99	1.04	0.76	0.91
55	0.93	0.97	1.06	0.99	1.08
65	0.98	1.17	1.71	2.56	2.37
75	1.04	1.58	3.13	6.08	5.30

a. Values for average age at first entry are in bold type.

For those with a mental primary disability, our findings indicate that their earnings ratios are generally below parity at the average age of entry, except for the severely disabled (IU and 100-percent disabled). We find that the severely disabled who enter at a young age are substantially below parity. Those who entered at age 65 or older generally were above parity, except for the 10-percent disabled group, which was still slightly below parity. Table 2 summarizes these findings.

Table 2. Earnings ratio by rating group and age at first entry for those with a mental primary disability (men)^a

Age at first entry	10%	20-40%	50-90% not IU	IU	100%
25	0.86	0.83	0.88	0.77	0.75
35	0.85	0.82	0.84	0.74	0.69
45	0.81	0.78	0.82	0.80	0.73
55	0.79	0.77	0.88	1.07	0.95
65	0.86	1.04	1.50	2.80	2.40
75	0.93	1.57	2.84	6.81	5.61

a. Values for average age at first entry are in bold type.

To summarize the earnings ratio findings for male veterans, there is general parity overall. However, when we explored various subgroups, we found that some were above parity, while others were below parity. The most important distinguishing characteristic is whether the primary disability is physical or mental. In general, those with a primary mental disability have lower earnings ratios than those with a primary physical disability, and many of the rating subgroups for those with a primary mental disability had earnings

rates below parity. In addition, entry at a young age is³ associated with below parity earnings ratios, especially for severely disabled subgroups.

Veterans' quality-of-life survey results

The second principal tasking from the Commission was to assess whether the current benefits program compensates not just for loss of average earnings, but also for veterans' quality-of-life degradation resulting from service-connected disability. Addressing this issue required collecting data from a representative sample of service-disabled veterans, which would allow us to estimate their average quality of life. To do this, we constructed, in consultation with the Commission, a survey to evaluate the self-reported physical and mental health of veterans and other related issues. CNAC's subcontractor, ORC Macro, conducted the survey and collected the data. As with the earned income analysis, we designed the survey to collect data by the major subgroup. We defined subgroups by the body system of the primary disability and combined disability rating, and three SMC categories. We were also able to characterize the survey results by IU status within the 50- to 90-percent disabled subgroup.

The survey utilized 20 health-related questions taken from a standardized bank of questions that are widely used to examine health status in the overall population. We used all questions from the short form 12 (SF-12TM) and eight additional questions from the short form 36 (SF-36TM). The SF-12TM questions allowed us to calculate a physical health summary score (physical component summary, or PCS) and a mental health summary score (mental component summary, or MCS). This approach is widely used to measure health status in a variety of national surveys, and it allowed us to compare the results for the service-disabled veterans to widely published population norms. We used the additional eight health-related questions to calculate five additional health subscales that also have widely published population norms.

For evaluating the survey, we decided to analyze the results by subgroup similar to the strategy we used for comparing earnings ratios. We looked at those with a primary physical disability and those with a primary mental disability separately. We also examined the PCS and MCS scores for additional subgroups within those categories. For the population norms, the PCS average is set at 50 points, and the norms decrease slightly with age. For the MSC scores, the population norm is quite flat at an average of 50, and decreases only for the oldest age categories.

3. Our analysis primarily focused on men because there are fewer service-disabled women. However, we conducted a parallel analysis for women when the data allowed and found very similar results.

For service-disabled veterans with a primary physical disability, we found that their PCS measures were below population norms for all disability levels, and that the scores were in general lower as the disability level increased. In addition, having a primary physical disability was not generally associated with reduced mental health as measured by MCS. Mental health scores for those with a primary physical disability were close to population norms, although those who were severely disabled had slightly lower mental scores.

For service-disabled veterans with a primary mental disability, we found that both the physical and mental component summary scores were well below population norms. This was true for each of the rating groups. This was a distinction from those with a primary physical condition, who (except for the severely disabled) did not have MCS scores below population norms. Figure 1 shows the comparison of scores for the PCS, grouped by nature of primary disability, and Figure 2 shows the comparison for the MCS.

Figure 1. PCS by rating and age group for those with physical compared to mental primary disabilities

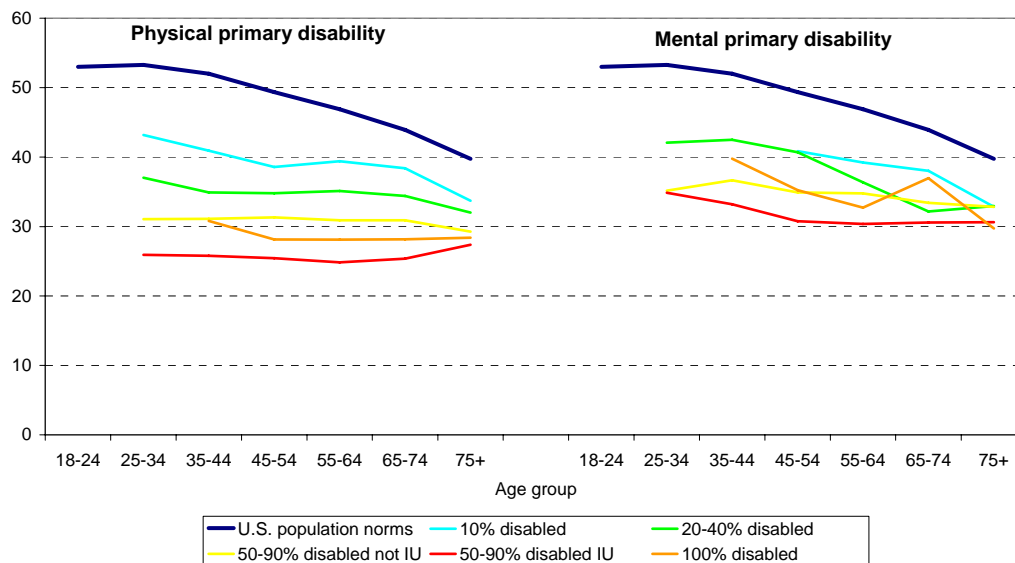
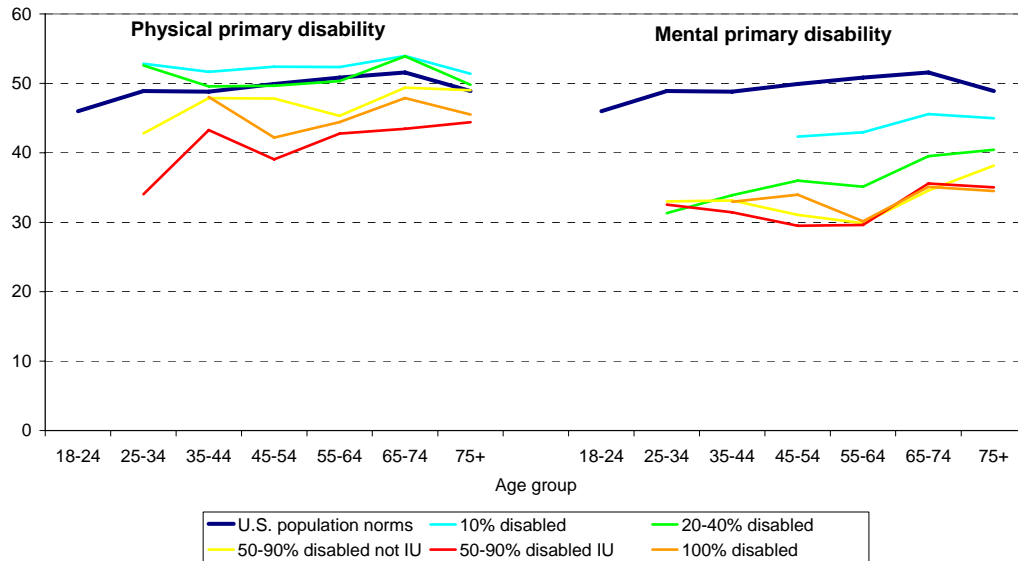


Figure 2. MCS by rating and age group for those with physical compared to mental primary disabilities

Figure 2. MCS by rating and age group for those with physical compared to mental primary disabilities



To summarize our overall findings, as the degree of disability increased, generally overall health declined. There were differences between those with physical and mental primary disabilities in terms of physical and mental health. Physical disability did not lead to lowered mental health in general. However, mental disability did appear to lead to lowered physical health in general. For those with a primary mental disability, physical scores were well below the population norms for all rating groups, and those with PTSD had the lowest PCS values.

We also used the Veterans Survey to investigate other issues that the Commission raised. First, we investigated whether service-disabled veterans tended to not follow recommended medical treatments because they felt it might impact their disability benefits. We used a series of indirect questions to ascertain this information. We found that this does not appear to be an issue, as less than one percent of those surveyed indicated that this was a motivation for them (0.45 percent).

In addition, the Commission asked us to investigate whether VA benefits created a disincentive to work for service-disabled veterans. Again, we used a series of indirect questions to ascertain this information. For example, a disincentive to work might be seen through working part-time instead of full-time, or retiring early, or not seeking work. We did not find this to be a major issue, as only 12 percent of the service-disabled veterans indicated that they might work, or work more, if it were not for the existence of their VA benefits. However, it must be noted that even within this 12 percent, it could be that these individuals felt that they would have no choice but to work more, if they had no VA benefits, and that it might be very difficult for them to actually increase their work efforts.

Combining earnings and quality-of-life findings for service-disabled veterans

The quality-of-life measures allow us to examine earnings ratio parity measures in the context of quality-of-life issues. In essence, the earnings parity measures allow an estimate of whether the VA compensation benefits provide an implicit quality-of-life payment. If a subgroup of service-disabled veterans has an earnings ratio above parity, they are receiving an implicit quality-of-life payment. At parity, there is no quality-of-life payment, and those with a ratio less than parity are effectively receiving a negative quality-of-life payment. What we can now do is consider the implicit quality-of-life payment in the context of the veterans' self-reported health status.

With regard to self-reported quality of life, we have multiple measures to consider, such as the PCS and MCS measures, and a survey question on overall life satisfaction. In addition, there is no intrinsic valuation of a PCS score of 42 compared to a score of 45. We know that a score of 45 reflects a higher degree of health than a score of 42 does, but we have no precise way to categorize the magnitude of the difference. To simplify the analysis, we combined the information from the PCS and MCS into an overall health score, with a population norm of 100 points (each scale had a norm of 50 points separately). Then we calculated the population percentile that would be attributed to the combined score. For example, for a score of 77 points, we know that 94 percent of individuals (based on population norms of 99 points) in the age range 45 to 54 would score above 77. This gives us a way to calibrate our results, in terms of how the overall physical and mental health of the service-disabled veterans compares to population norms. By construction, the 50th percentile is the population norm of this measure.

The results of this analysis confirmed our earlier finding that there are more significant health deficits for those with a primary mental disability than a primary physical disability. We found that overall health for those with a mental primary disability is generally below the 5th percentile in the typical working years for those who are 20 percent or more disabled (this would represent a combined score of 77, compared to a population norm of 99, for those age 45 to 54). Even for the 10-percent group, the overall health score is generally below the 20th percentile (a combined score of 83 instead of the norm of 99 for those age 45 to 54).

This approach allows us to display the implicit quality-of-life payment, based on the parity of the earnings ratio, and to look at it alongside the overall health percentile and the overall life satisfaction measure (the percentage of respondents who say that they are generally satisfied with their overall life). We investigated this by rating groups and average age at first entry, separately for those with a physical primary disability compared to a mental primary disability. We show the results in tables 3 (physical primary disability) and 4 (mental primary disability), with the implicit quality-of-life payment on

row 5, followed by the overall health percentile and the overall life satisfaction on rows 6 and 7.

Table 3. Earnings and quality-of-life analysis by rating group for those with a physical primary disability (men)

	10%	20-40%	50-90% (not IU)	IU	100%
Average age at first entry	45	45	55	55	55
Annual VA compensation	\$1,288	\$3,944	\$11,343	\$28,421	\$28,703
Annual earned income loss	\$2,543	\$4,385	\$9,934	\$28,798	\$25,782
Earnings ratio	0.96	0.99	1.06	0.99	1.08
Implicit QOL payment	(\$1,255)	(\$441)	\$1,409	(\$377)	\$2,921
Overall health percentile ^a	28%	15%	6%	2%	4%
Overall life satisfaction	78%	73%	64%	58%	60%

a. The comparison group value for the overall health percentile: 50 percent.

b. There is no comparison group value for overall life satisfaction.

Table 4. Earnings and quality-of-life analysis by rating group for those with a mental primary disability (men)

	10%	20-40%	50-90% (not IU)	IU	100%
Average age at first entry	45	45	55	55	55
Annual VA compensation	\$1,294	\$4,629	\$11,084	\$28,253	\$28,034
Annual earned income loss	\$7,676	\$12,603	\$14,571	\$26,567	\$29,926
Earnings ratio	0.81	0.78	0.88	1.07	0.95
Implicit QOL payment	(\$6,381)	(\$7,974)	(\$3,487)	\$1,686	(\$1,892)
Overall health percentile ^a	13%	6%	1%	<0.5%	1%
Overall life satisfaction	61%	48%	32%	28%	29%

a. The comparison group value for the overall health percentile: 50 percent.

b. There is no comparison group value for overall life satisfaction.

For those with a physical primary disability, the average age at first entry varies from 45 to 55, rising with the combined degree of disability. For 10-percent and 20- to 40-percent disability, there is a negative quality-of-life payment, although their overall health percentile ranges from 28 to 15 percent. For these groups, the overall life satisfaction ranges from 78 to 73 percent. For higher disability groups, there is a modest positive quality-of-life payment, ranging as high as \$2,921 annually for the 100-percent disabled group. For the 100-percent disabled group, the overall health percentile is 4, meaning that 96 percent of the population would have a higher health score than the average score for this subgroup, and the overall life satisfaction is only 60 percent.

Looking at the service-disabled veterans with a mental primary disability, as table 4 shows, we see that there is an implicit negative quality-of-life payment for veterans of all disability levels except for IU. Also, for these subgroups, the overall health percentile is at the 13th percentile for 10-percent disabled and at the 6th percentile for 20- to 40-percent disabled. In fact, for the higher disability groups, the overall health score is at or below one percent, meaning that 99 percent of the population would have a higher overall health score. Overall life satisfaction, even for the 10-percent disability level, is only 61 percent. For disability levels 50- to 90-percent, IU, and 100-percent disabled, the overall life satisfaction measure hovers around 30 percent.

With regard to the existence of implicit quality-of-life payments, we found positive quality-of-life payments for those with a physical primary disability at a combined rating of 50 to 90 percent or higher (except for IU). For those with a mental primary disability, we found that there is a positive quality-of-life payment only for the IU subgroup. In comparing overall health percentiles and life satisfaction, however, we found that for all rating groups, those with a mental primary disability have lower overall health percentiles, and substantially lower overall life satisfaction, than those with a physical primary disability. Those with a mental primary disability have lower health and life satisfaction compared to those with a physical primary disability, but receive less in implicit quality-of-life payments.

To summarize, we found that VA compensation is about right overall relative to earnings losses based on comparison groups for those at the average age at first entry. But the earnings ratios are below parity for severely disabled veterans who enter the system at a young age and more generally below parity among subgroups for those with a mental primary disability. Earnings ratios tend to be above parity for those who enter the VA system at age 65 or older. On average, VA compensation does not provide a positive implicit quality-of-life payment. Finally, the loss of quality of life appears to be greatest for those with a mental primary disability.

Earnings and quality-of-life findings for survivors

We computed earnings profiles for survivors using a methodology analogous to that used for service-disabled veterans. We calculated earnings income by age group and compared these earnings levels to the earnings of surviving spouses in the general civilian population. Segmenting by age group is critical as 69 percent of survivors are 65 or more years old.

We also constructed and conducted a survey for survivors to assess how their self-reported health compared to population norms. As there were relatively few male survivors, we focused our comparisons of female survivors and their female peers from the Current Population Survey (CPS). The Commission asked us to explore how well Dependency and

Indemnity Compensation (DIC) provides a partial replacement for lost earnings attributed to the loss of a service member or veteran in service-related circumstances.

The earnings comparisons show that on average survivors generally have lower earnings than their civilian peer groups, but that the combination of earned income plus VA compensation is as high as, or higher than, the average earned income of their peer groups at every age. In addition, based on our survey results, 90 percent of the respondents said that they were satisfied with DIC. We conclude that DIC appears to provide an adequate replacement for lost earnings for survivors.

The health differences among survivors and their peers are not as dramatic as the health differences were for service-disabled veterans and their peers, but there are some departures from population norms. The PCS for survivors is below population norms for age 55 and over, and the MCS is below population norms for ages 35 to 64. These findings are unaffected by whether or not the survivors had a Survivor Benefit Plan (SBP) offset, or whether it was less than 5 years or 5 or more years since their spouse died. We also asked the survivors whether they provided substantive care for a disabled veteran (4 or more hours per day, 5 days a week, for 2 or more years). Those survivors who provided substantive care to a disabled veteran appeared to suffer some negative effects on physical health and participation in social activities.

Raters and VSOs survey results

With regard to the benefits determination process, the Commission asked us to gather information by conducting surveys of VBA rating officials and accredited veterans service officers (VSOs) of National Veterans Service Organizations (NVSOs). The intent was to gather insights from those who work most closely with the benefits determination and claims rating process. Through consultation with the Commission, we constructed separate (but largely parallel) surveys for raters and VSOs. The surveys focused on the challenges in implementing the laws and regulations related to the benefits determination and claims rating process and perspectives on how the process and rating schedule perform.

The content of the surveys looked at issues involving training, proficiency on the job, and resource availability and usage. Respondents were asked about what they considered to be their top three job challenges. They were also asked about how they decided or established specific criteria related to a claim, how smoothly the rating process went, and the perceived capabilities of the various participants in the process.

The overall assessment indicated that the benefits determination process is difficult to use by some categories of raters. Many VSOs find it difficult to assist in the benefits determination process. In addition, VSOs report that most veterans and survivors find it difficult to understand the determination process and difficult to navigate through the

required steps and provide the required evidence. Most raters and VSOs agreed that veterans have unrealistic expectations of the claims process and benefits.

Raters and VSOs noted that additional clinical input would be useful, especially from physicians and mental health professionals. Raters felt that the complexity of claims is rising over time, and that additional resources and time to process claims would help. Some raters felt that they were not adequately trained or that they lacked enough experience. They viewed rating mental disorder claims as more problematic than processing physical condition claims. They viewed mental claims, especially PTSD, as requiring more judgment and subjectivity and as being more difficult and time-consuming compared to physical claims. Many raters indicated that the criteria for IU are too broad and that more specific decision criteria or evidence would help in deciding IU claims.

VA disability compensation program compared to other disability programs

The Commission was also interested in operational aspects of the veterans' disability compensation program and asked us to compare VA's program with other federal disability compensation programs in order to determine whether there are any useful practices that VA could adopt to improve its own operations. Our first task was to identify the major criticisms of operations in the VA disability program. To do that, we reviewed a variety of publicly available sources that discussed problems with VA performance, including reports from the Government Accountability Office (GAO), reports from the VA Office of the Inspector General (OIG), and congressional testimony. We also used the results of the Commission's site visits.

After identifying the major criticisms of VA, we spoke with the relevant VA staff to get the most current information on the areas being criticized. The people that we interviewed worked in VBA's Compensation and Pension Service, VBA's Office of Employee Development and Training, the Board of Veterans' Appeals, and the Office of the General Counsel. We discussed specific aspects of VA operations that were identified as problematic and the approaches that the other disability programs take in those areas.

Except for the very important issue of timeliness, VA does not appear to be underperforming in comparison with other disability programs. Recent training improvements seem promising for improving VA timeliness in the long term, but effects will not be seen for a while. Some of VA's problems with timeliness could be the result of a complex program design, with multiple disabilities per claim, the need to determine service connection (sometimes many years after separation), and the need to assign a disability rating to each disability. For VA to develop a focused strategy to improve timeliness, it first needs to determine the stages of the claims process that are contributing most to the total elapsed time required to complete a claim.

Option for a lump sum alternative

The Commission asked us to explore options for replacing the current annuity benefits stream for some service-disabled veterans with a lump sum alternative. We looked at this from the perspective of the potential benefits and costs both to the VA and to service-disabled veterans, and with respect to potential implementation barriers. We also investigated how other countries use a lump sum alternative for their service-disabled veterans. We focused on exploring possible options for those at the lowest disability levels (10 to 20 percent). In addition, we determined that this would be most feasible for body systems where rating changes were infrequent, as re-rating might generate the need to recalculate lump sum payments or provide an annuity.

For the VA, the anticipated benefits of a lump sum derive primarily from the potential for reduced administrative interactions (which might lead to speedier claims processing) and savings in compensation and administrative costs. If the lump sum were optional, this would increase the choices open to service-disabled veterans. Finally, there are a number of concerns about how the lump sum amounts would be determined, what would happen if a veteran's condition worsened after he/she had taken a lump sum, and whether veterans would use a lump sum "wisely" or not.

We looked at Australia's, Canada's, and the United Kingdom's disability compensation systems for their service-disabled veterans, all of which utilize some version of a lump sum alternative. These countries generally use an annuity system to compensate for "economic" losses, and reserve the lump sum for compensating for "non-economic" or quality-of-life losses. Canada and the UK use lump sums to compensate for lost quality of life, while Australia offers the veteran a choice between an annuity and a lump sum.

We made a number of simplifying assumptions and selected a small number of examples to simulate how a lump sum program might be implemented. We found that the VA could obtain net savings, but a lump sum option would be costly up front, taking between 17 and 25 years for the VA to achieve net savings. In addition, we identified a number of institutional issues that would pose execution challenges, thereby limiting the value of the lump sum option to the VA.

IU and mortality

The Commission asked us to conduct an analysis of those receiving the individually unemployable (IU) designation. This designation is for those who do not have a 100-percent combined rating but whom VA determines to be unemployable. The designation enables them to receive disability compensation at the 100-percent level.

Overall 8 percent of those receiving VA disability compensation have IU, but 31 percent of those with PTSD as their primary diagnosis have IU status. Ideally, if the rating schedule works well, the need for something like IU will be minimal because those who need 100-percent disability compensation will get it from the ratings schedule. The fact that 31 percent of those with PTSD as their primary condition have IU is an indication that the ratings schedule does not work well for PTSD.

Another issue is the rapid growth in the IU rolls—from 117,000 in 2000 to 223,000 in 2005. This represents a 90-percent increase, an increase that occurred while the number of disabled veterans increased 15 percent and the total number of veterans declined by 8 percent. The specific issue is whether disabled veterans were gaming the system to get IU status to increase their disability compensation.

The data suggest that this is not the case. While there has been some increase in the prevalence of getting IU status for certain rating-and-age combinations, the vast majority of the increase in the IU population is explained by demographic changes (specifically the aging of the Vietnam cohort) in the veteran population.

We can also use mortality rates to see to what degree gaming is an issue for IU. Do those with IU have higher mortality rates than those without IU? If so, it seems that there is a clinical difference between those with and without IU. We found that there are differences. Those with IU status have higher mortality rates than those rated 50-90 percent without IU, but the IU mortality rates are less than for the 100-percent disabled.

Comparison of DOD/VA disability ratings

Due to concern with consistency of DOD and VA disability ratings, the Commission asked CNAC to study the issue. We first looked to see how much overlap there was between the two systems. We found that roughly four-fifths of those who receive a DOD disability rating end up in the VA compensation system in less than 2 years.

Next we explored whether DOD and VA gave approximately the same combined disability rating. On average, we found that service-disabled veterans received substantially higher ratings from VA than from DOD. The question is why? The answer is twofold. First, VA rates more conditions than DOD does. Specifically, we found that on average VA rates about three more conditions per person than DOD does. Second, we found that even at the individual diagnosis level, VA gives higher ratings than DOD does on average. This is not universally true for all diagnostic codes. For some, the average rating from DOD is slightly higher than from VA. But for others, such as mental diagnostic codes, the average rating from VA is substantially higher than the rating from DOD.

Note that while we found differences in combined and individual ratings given by DOD and VA, we make no judgment as to the correctness of the ratings in either system. We have neither the data nor the clinical expertise to make such judgments. What we have done is point out aspects of the VA and DOD disability systems that differ.

Overall options and recommendations

There are several options for addressing (1) the lack of earnings parity where it exists and for (2) compensation for lost quality of life. Earnings parity of those with mental conditions could be improved through higher ratings for mental conditions or special monthly compensation similar to that currently paid for other conditions. The issue with using higher ratings is that this would require re-rating all of those with a mental disability.

Earnings parity for the severely disabled who enter the system at “young” ages could be improved by making disability compensation levels a function of age at first entry into the disability system or through a special monthly compensation paid only to those with a severe disability who enter the system at a young age. It may also be appropriate to consider adjusting VA compensation for those who enter the system at “older” ages.

Another issue is the individual employability (IU) designation that many veterans receive because they are unemployable. If the purpose of this designation truly relates to employment, there could be a maximum eligibility age reflecting typical retirement patterns. If the purpose is to correct for rating schedule deficiencies, an option is to correct the ratings schedule so that fewer need to be artificially rated 100-percent through IU. This would reduce the administrative burden of individual means testing associated with IU.

Turning to quality-of-life compensation, options include a lump sum payment or an annuity. This annuity could simply be an add-on to the current VA compensation. The difficult question is how much should this compensation be? The fact is that there is no way to translate the quality-of-life losses documented in the Veterans Survey into a dollar amount, so we looked for some kind of benchmark. One possibility is to use the non-economic compensation provided by other countries to their disabled veterans as a benchmark. We note, however, that due to differences between these and the U.S. program, it is not an apples-to-apples comparison. This fact should be considered when making these comparisons.

Turning to data issues, there are ways in which the VA could be enhanced to facilitate future analysis. These include a periodic authorization link to SSA and OPM compensation records with VA data to allow for future earning analysis at a more granular level than we were able to perform with aggregated data. We also recommend that VA include demographic information in its records because these data are key predictors in

economic analysis. Finally, because when a service-disabled veteran first enters the VA system is a driver of earnings parity, we recommend that VA maintain and not overwrite the original award date.

Another issue that emerges from the data concerns service-disabled veterans with a mental primary disability. Their overall health percentiles and overall life satisfaction percentiles are far below those with physical primary disabilities at the same rating level. Their earnings are well below those with physical primary disabilities at every rating category except IU. These data clearly indicate that their life experience is less satisfying than that of their counterparts. An important question, beyond the scope of this analysis, is how veterans' programs could be made more effective at benefiting this group of veterans.

Appendix G

Comparison of DoD Disability Ratings with VA Disability Ratings for the Same Conditions

Figures G.1 through G.13 show the distribution of VA ratings by DOD rating for 13 distinct medical conditions: arthritis, lumbosacral or cervical strain, asthma, intervertebral disc syndrome, major depressive disorder, PTSD, diabetes mellitus, bipolar disorder, migraine headaches, traumatic brain injury, knee condition, seizure disorder, and sleep apnea.

Figure G.1 Comparison of DOD and VA ratings for arthritis

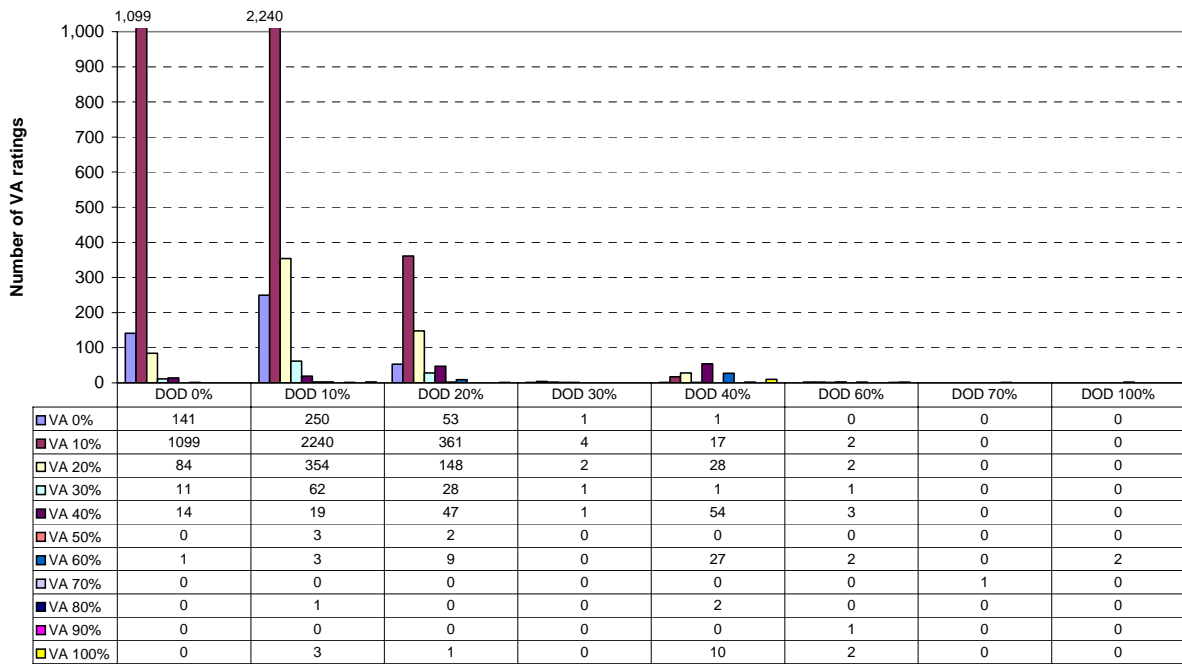


Figure G.2 Comparison of DOD and VA ratings for lumbosacral or cervical strain

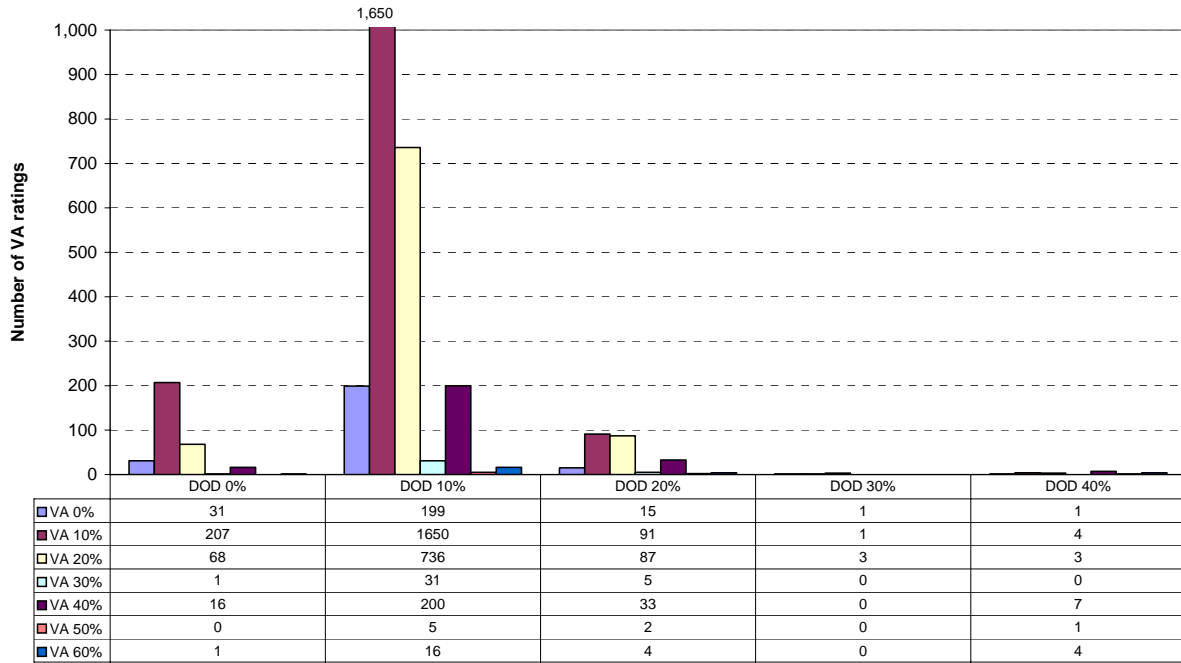


Figure G.3 Comparison of DOD and VA ratings for asthma

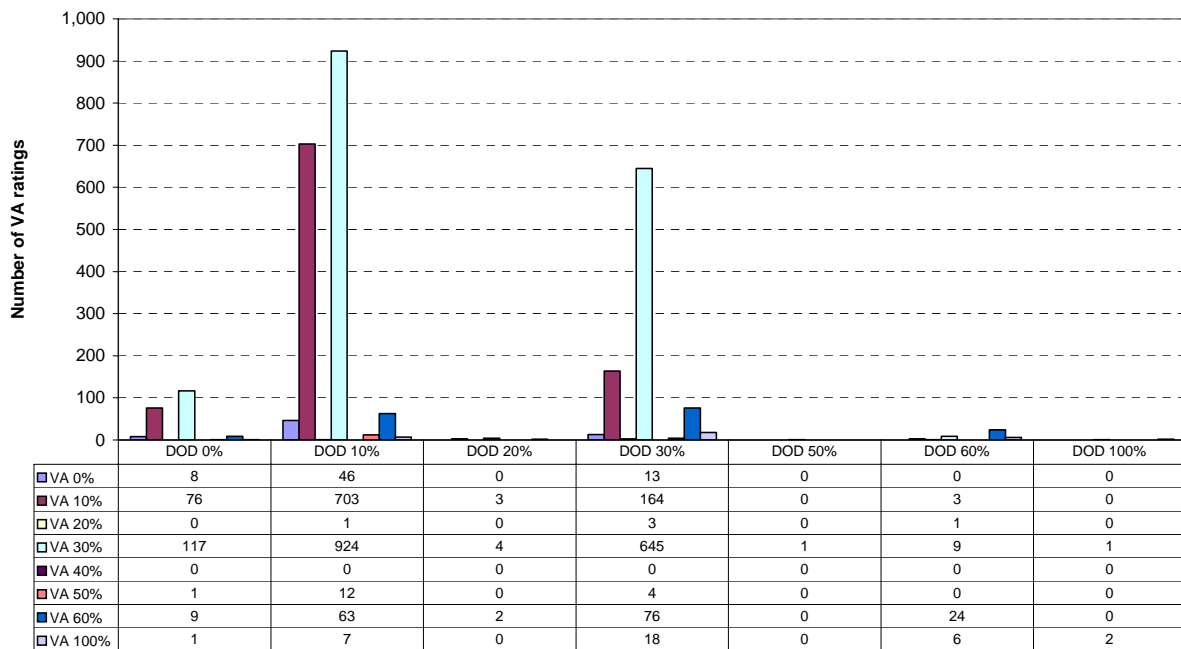


Figure G.4 Comparison of DOD and VA ratings for intervertebral disc syndrome

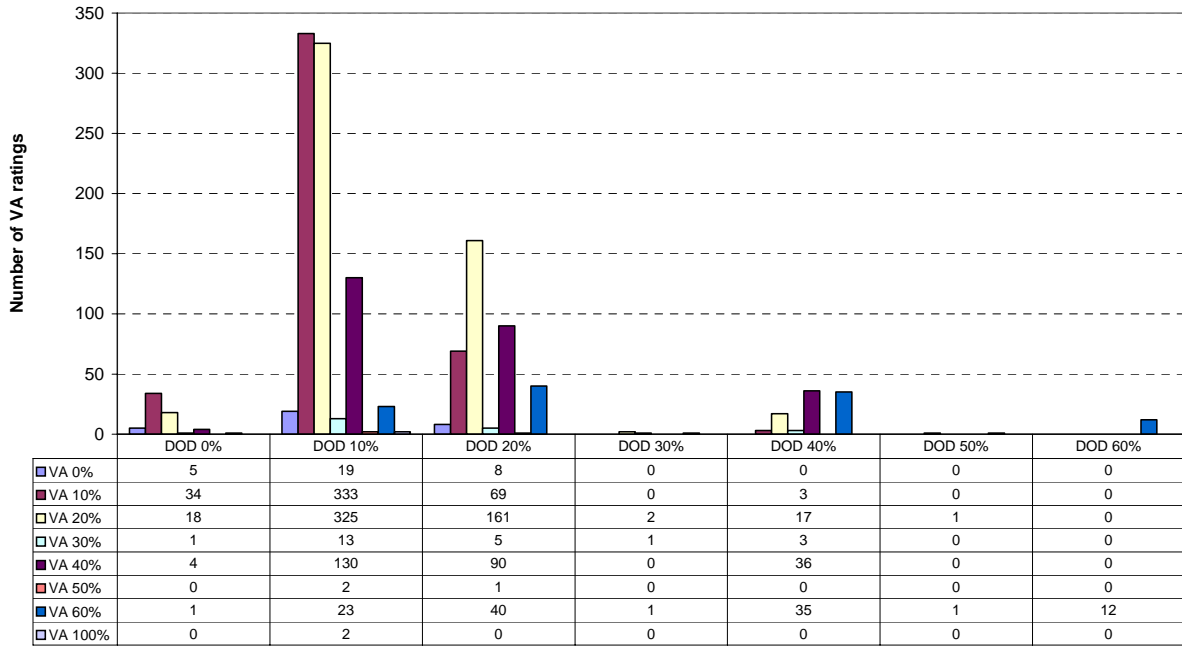


Figure G.5 Comparison of DOD and VA ratings for major depressive disorder

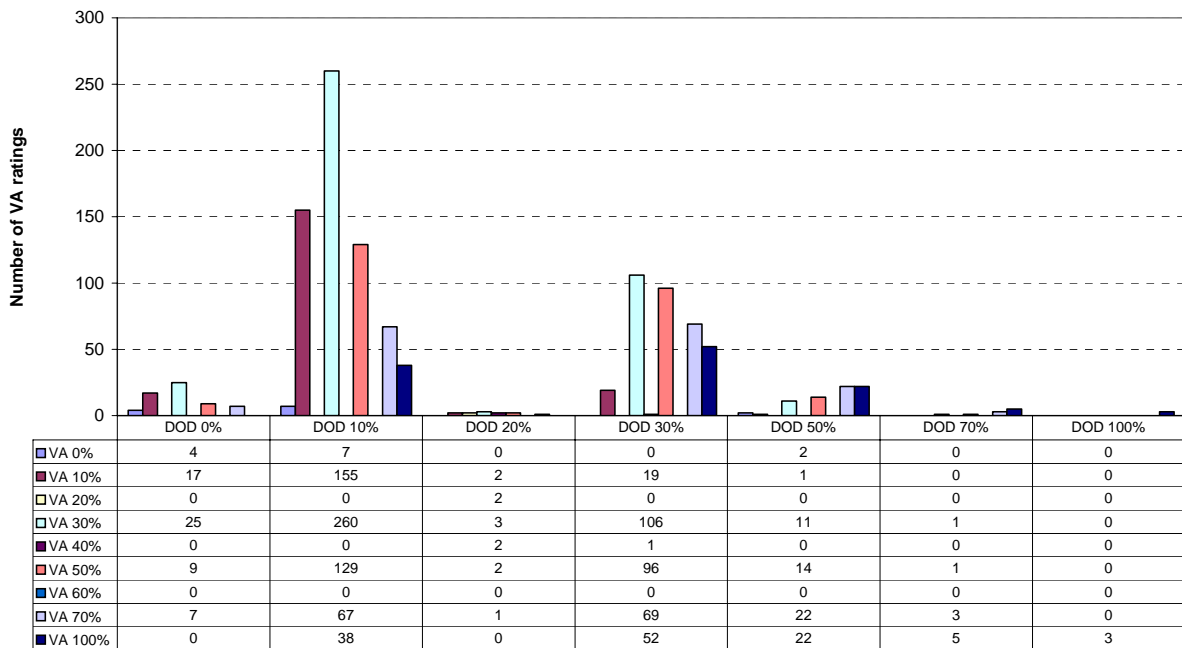


Figure G.6 Comparison of DOD and VA ratings for PTSD

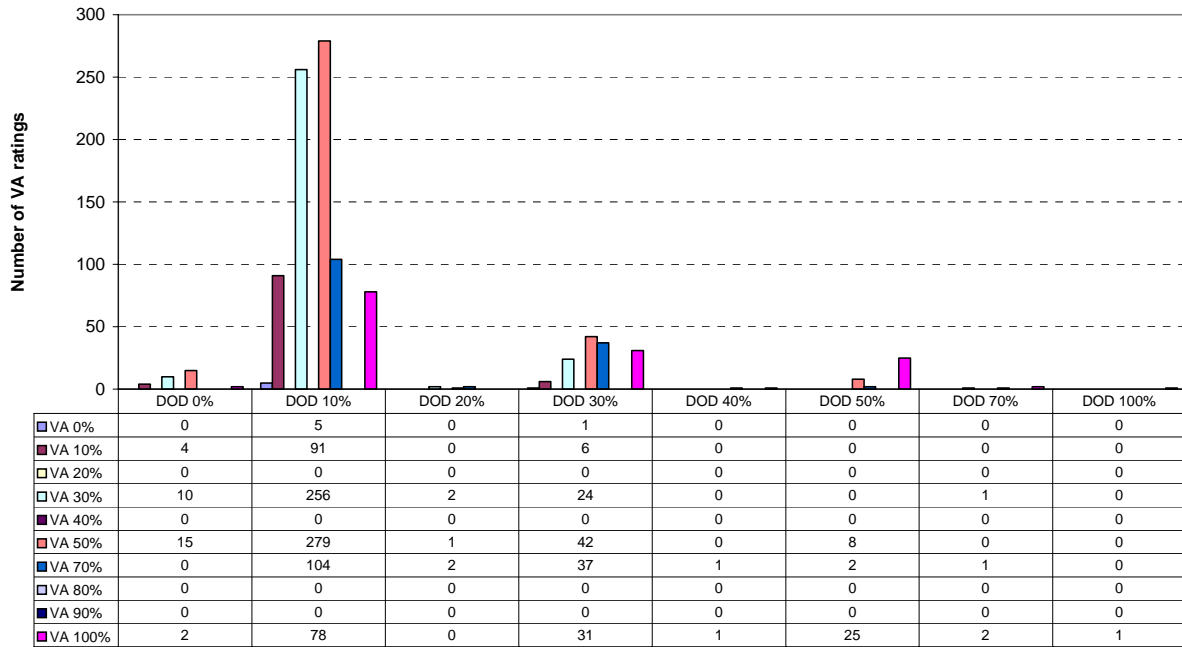


Figure G.7 Comparison of DOD and VA ratings for diabetes mellitus

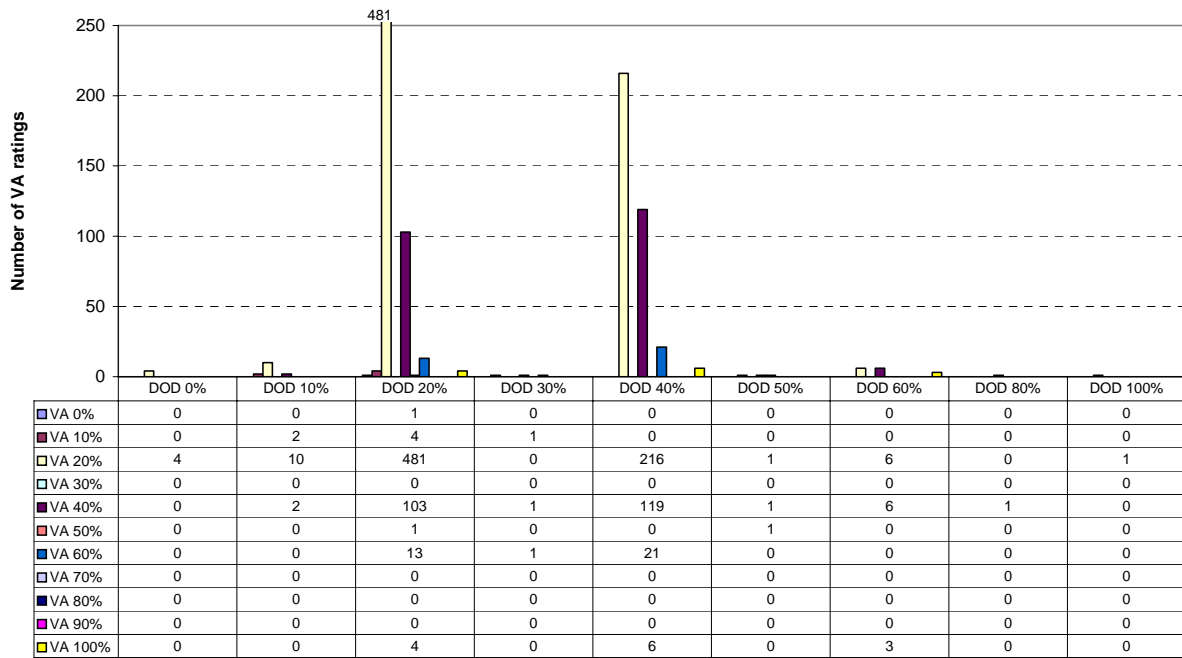


Figure G.8 Comparison of DOD and VA ratings for bipolar disorder

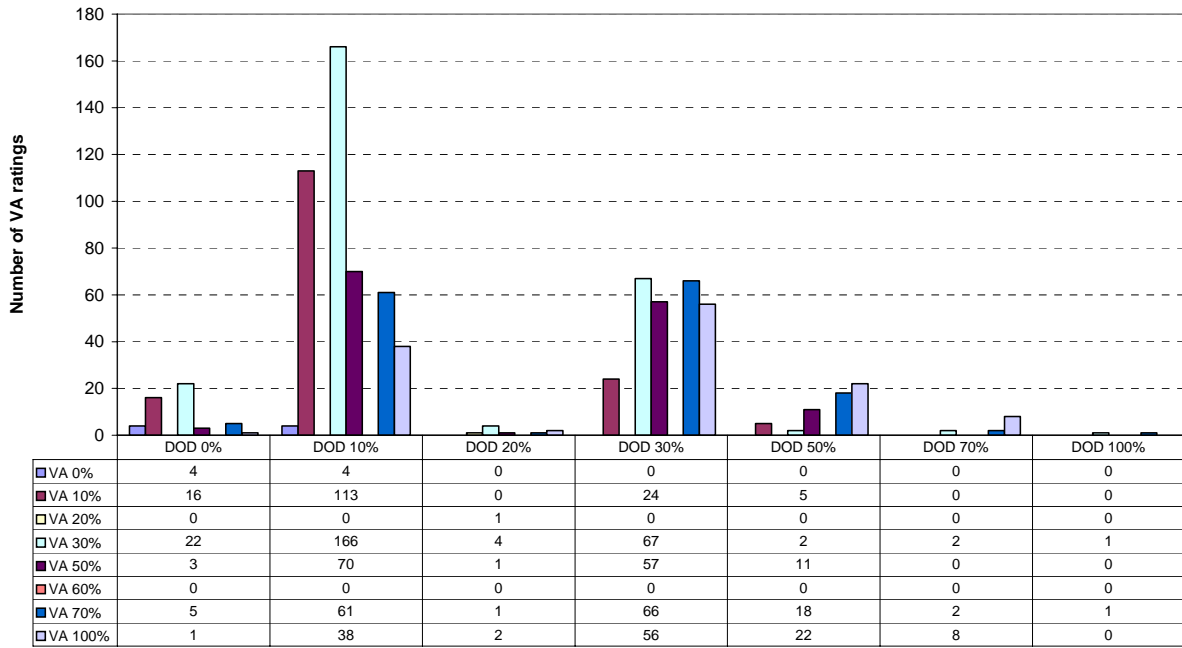


Figure G.9 Comparison of DOD and VA ratings for migraine headaches

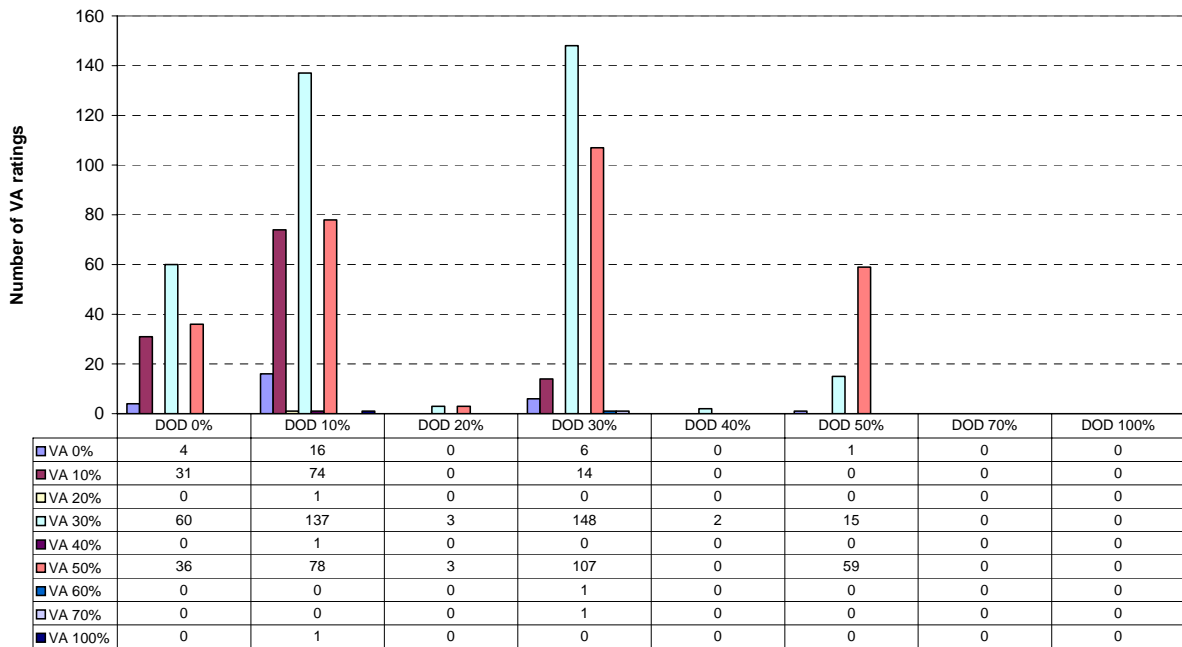


Figure G.10 Comparison of DOD and VA ratings for traumatic brain injury

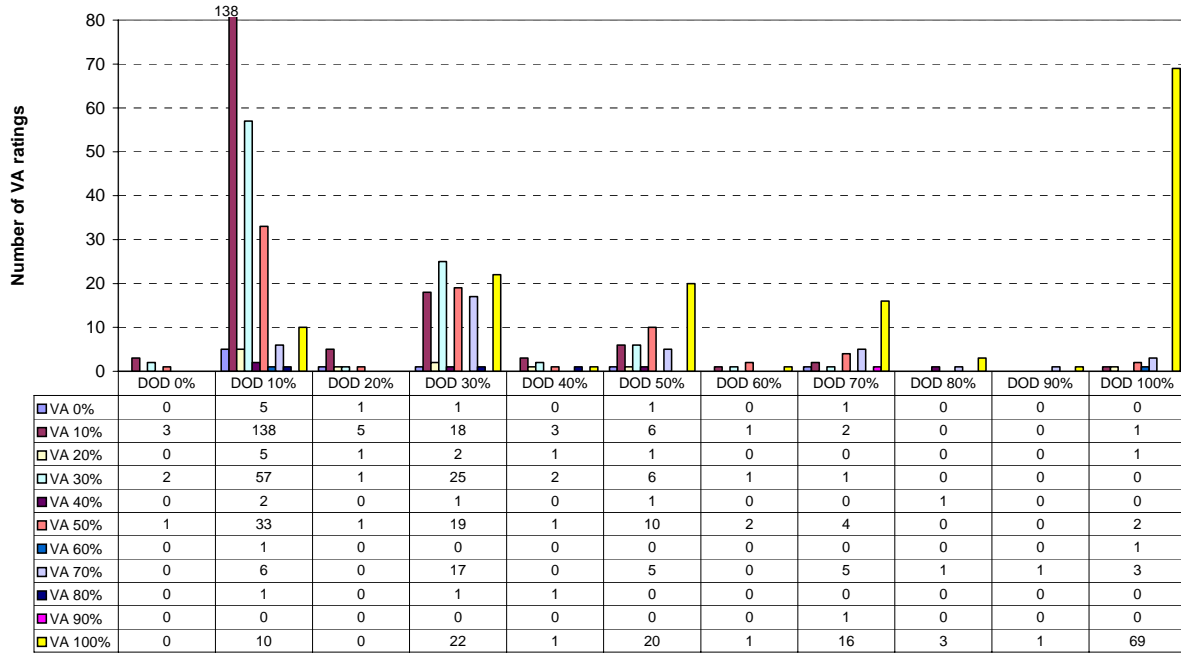


Figure G.11 Comparison of DOD and VA ratings for knee condition

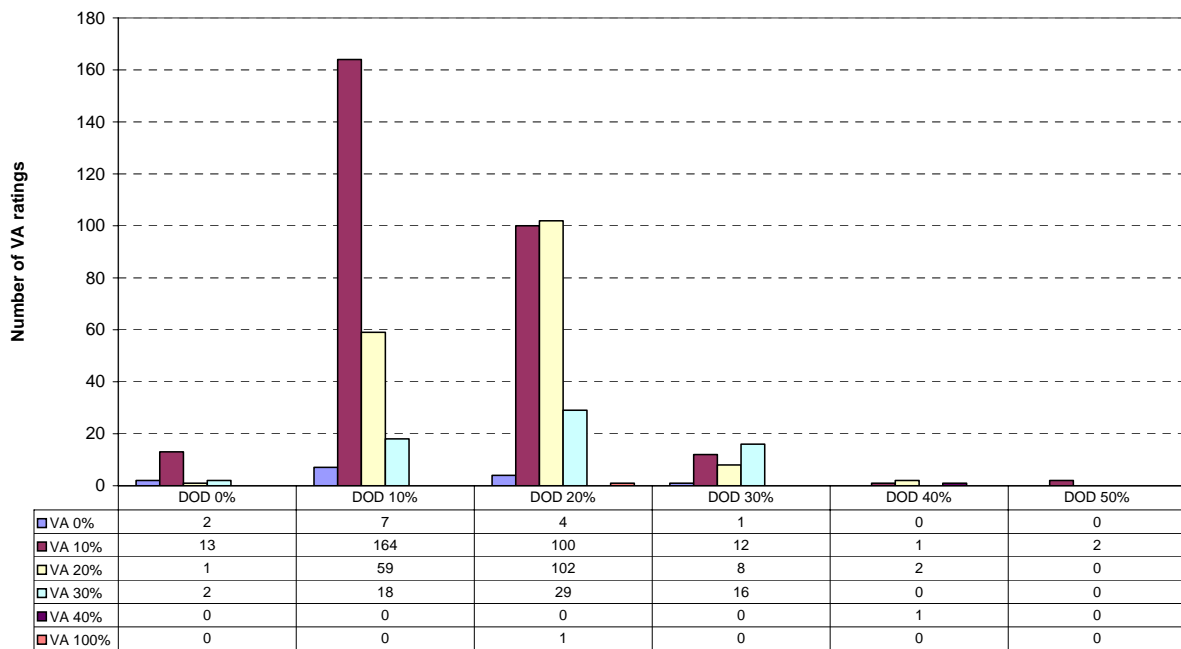


Figure G.12 Comparison of DOD and VA ratings for seizure disorder

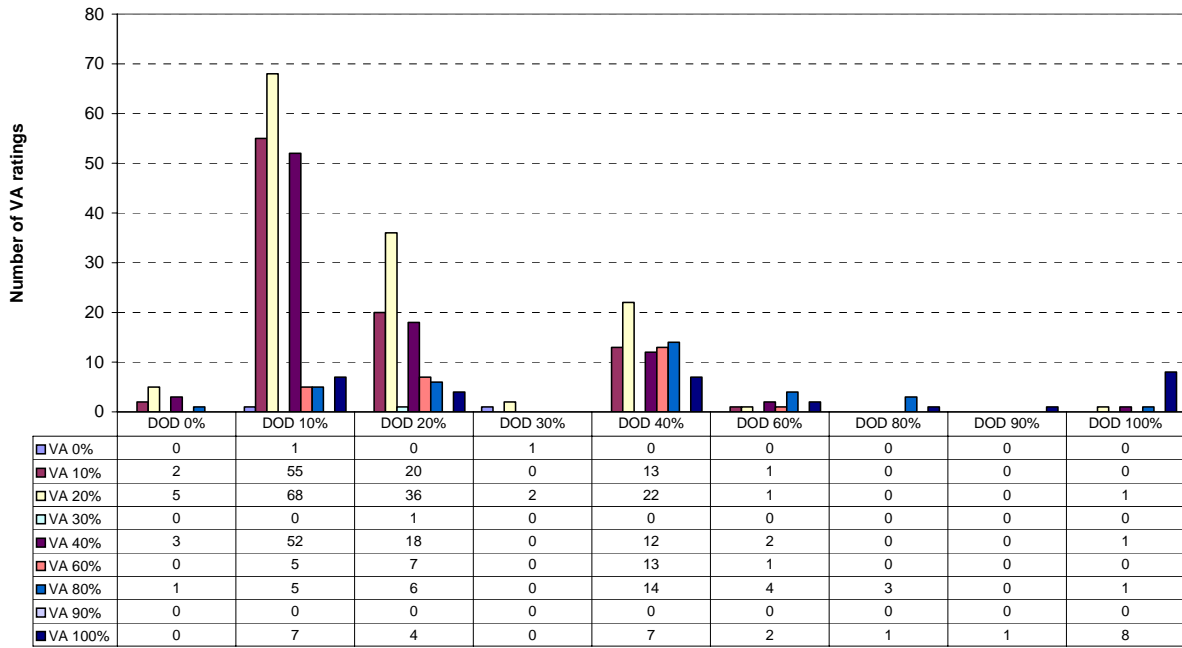
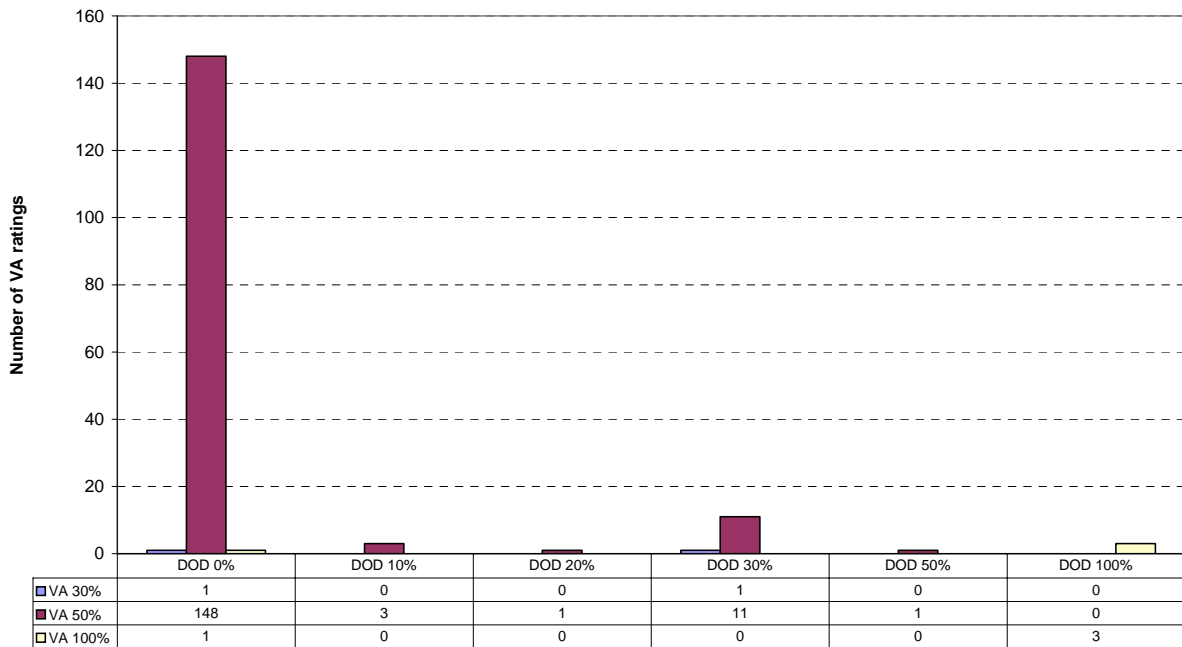


Figure G.13 Comparison of DOD and VA ratings for sleep apnea syndromes



Appendix H

Summary of *A 21st Century System for Evaluating Veterans for Disability Benefits*

The Commission contracted with the Institute of Medicine (IOM) to conduct a comprehensive study of the VA Schedule for Rating Disabilities. IOM convened a committee of experts to perform that task; their final report is titled *A 21st Century System for Evaluating Veterans for Disability Benefits*. This appendix contains the summary from that report. The full report is available from The National Academies Press at www.nap.edu.

Summary

ABSTRACT: *The Department of Veterans Affairs (VA) compensates veterans for injuries and diseases acquired or aggravated during military service. Currently (2007), the amount of monthly compensation to a veteran without dependents ranges from \$115 for a 10 percent rating to \$2,471 for a 100 percent rating. Approximately 2.8 million veterans are receiving compensation totaling about \$30 billion a year (dependents and survivors receive another \$5 billion a year). The rating is determined using the VA Schedule for Rating Disabilities (Rating Schedule), which has criteria based mostly on degree of impairment—i.e., loss of body structures and systems. This report recommends that VA comprehensively update the entire Rating Schedule and establish a regular process for keeping it up to date. VA should dedicate staff to maintaining the Rating Schedule and reestablish an external advisory committee of medical and other disability experts to assist in the updating process. The report also recommends that the current statutory purpose of VA's disability compensation program—to compensate for average loss of earning capacity—should be expanded to compensate for nonwork disability and loss of quality of life as well as average loss of earning capacity. VA should investigate how well the rating levels correspond to average loss of earnings and adjust rating criteria to ensure that as ratings increase, average loss of earnings also increases (vertical equity), and that the same ratings are associated with similar average losses of earnings across body systems (horizontal equity). VA should also apply measures of functional limitations, such as activities of daily living and instrumental activities of daily living, and determine if the Rating Schedule accounts for them (i.e., as limitations on ability to engage in usual life activities increase, ratings tend to increase). If not, VA should incorporate functional criteria in rating criteria or develop a separate mechanism for compensating for functional limitations beyond work disability. The methodology for measuring quality of life (QOL) is not as well developed as it is for measuring functional limitations. Accordingly, VA initially should engage in research and development efforts to create measures valid for the veteran population before determining if the Rating Schedule compensates for QOL (i.e., as quality of life diminishes, ratings generally increase) and, if it does not, develop a mechanism for compensating for loss of QOL clearly beyond loss in earnings or limitations in daily life. The report also addresses a number of other top-*

ics, for example, use of computer-based templates to improve disability examinations; better training of examiners and raters; adoption of commonly used diagnostic classification systems; comprehensive needs assessment of veterans separating from military service for health care, vocational rehabilitation, educational, and other benefits and services provided by VA; involvement of vocational expertise in determining individual unemployability; and research to improve the rating process (e.g., analyses of the validity and reliability of the Rating Schedule, evaluate training and certification programs, and assess the extent to which compensation and ancillary benefits meet the needs of veterans).

INTRODUCTION

The Institute of Medicine (IOM) was asked by the Veterans' Disability Benefits Commission to study and recommend improvements in the medical evaluation and rating of veterans for the benefits provided by the Department of Veterans Affairs (VA) to compensate for illnesses or injuries incurred in or aggravated by military service. The main topics examined in this report by the committee formed to undertake the study are VA's "Schedule for Rating Disabilities"—usually referred to as the "Rating Schedule"—and the development of medical information in the evaluation of veterans claiming disability and the use of that information in the rating process.

Compensation for service-connected disability is a monthly cash benefit made to veterans who are disabled due to an illness or injury that occurred during service or was aggravated by service. Raters use the Rating Schedule to determine degree of disability, ranging in 10 percent increments from 0 to 100 percent, and a veteran's benefit level is tied to his or her rating. Benefits in 2007 range from \$115 a month for a 10 percent rating to \$2,471 for a 100 percent rating (plus additional amounts for dependents of those with 30 percent ratings or higher).

The statutory purpose of disability benefits is to compensate veterans for "the average impairments of earning capacity resulting from such injuries in civil occupations." VA program policies clearly reflect a grateful nation. They include deciding in favor of the veteran if there is reasonable doubt; assisting the veteran in gathering evidence; identifying conditions that might be compensable even if the veteran does not claim them; and presumption of service connection for certain conditions. A disability rating also entitles a veteran to ancillary services, such as vocational rehabilitation and employment services, and higher ratings provide access to more benefits, such as free health care. The compensation is tax exempt, and there are annual cost-of-living adjustments.

It is important that the tool used to determine the rating—the Rating Schedule—be as effective as possible in fulfilling the purpose of the compensation program. Is it valid and reliable in determining degree of disability? Is it up to date, and are there adequate arrangements for keeping it up to date? Are there better ways of evaluating disability? This report addresses these and related questions and makes recommendations for improvements.

IMPAIRMENT, DISABILITY, AND QUALITY OF LIFE

The statutory purpose of the cash benefits currently provided to veterans with disabilities is to compensate for the work disability ("average impairment in earning capacity") resulting from service-related injuries and diseases. In practice, Congress and VA have implicitly recognized consequences in addition to work disability of impairments suffered by veterans in the Rating

Schedule and other ways. Modern concepts of disability include work disability, nonwork disability, and quality of life, although not all of the tools used to operationalize the evaluation of this broader concept of disability are well developed. The Rating Schedule currently emphasizes impairment and limitations or loss of specific body structures and functions, which may not predict disability well. However, the Rating Schedule could be revised to include factors that are more directly related to disability, such as activities of daily living and other whole-person-level functional limitations. It also may be possible to develop procedures to measure and compensate for loss of quality of life. Revising the Rating Schedule would be greatly assisted by a clearer definition of the purpose of compensation.

Recommendation 3-1.¹ The purpose of the current veterans disability compensation program as stated in statute currently is to compensate for average impairment in earning capacity, that is, work disability. This is an unduly restrictive rationale for the program and is inconsistent with current models of disability. The veterans disability compensation program should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss in quality of life. (Specific recommendations on approaches to evaluating each consequence of service-connected injuries and diseases are in Chapter 4.)

The committee is aware that adopting Recommendation 3-1 would be difficult and costly. Legislative endorsement would be very helpful, if not required. If the recommendation is adopted, the Rating Schedule and the procedures needed to implement it will need to be revised to reflect the expanded purposes for disability benefits endorsed by the committee. This can be done in phases, after appropriate research and analysis and pilot projects to study the feasibility of changes. This issue is addressed in Chapters 4 and 5.

Expanding the bases for veterans disability compensation also has cost implications. There will be start-up costs incurred in developing the instruments for evaluating degree of functional limitation and loss of QOL, transitional costs such as training, and possibly greater compensation costs (if functional or QOL deficits are greater on average than are accounted for using the current impairment ratings). Although the committee was not asked to consider costs in recommending improvements in medical evaluation of veterans for disability benefits, the issue is addressed at the end of Chapter 4.

In addition, if disability compensation is considered in the larger context of veterans benefits, in conjunction with today's views on the rights of individuals with disabilities to live as full a life as possible, it is possible to envision a more comprehensive evaluation of a veteran's needs—including medical, educational, vocational, and compensation. Currently, the assessment process is piecemeal and fragmented. Either the veteran must receive a rating to access related services, such as health care and vocational rehabilitation and employment services, or the other service, such as education, is separate. This issue is addressed in Chapter 6.

¹ Recommendations used throughout the Summary and the rest of the report are numbered according to the chapter in which they appear and the order in which they appear in that chapter. Thus Recommendation 3-1, which is the first recommendation in the report, is the first recommendation to appear in Chapter 3. See Box S-1 for all of the recommendations, categorized according to the committee's specific tasks.

THE RATING SCHEDULE

Updating the Rating Schedule

It is important for the Rating Schedule to be as up to date as possible in current medical approaches and terminology to serve veterans with disabilities most effectively. This ensures that the criteria in the Rating Schedule are based on concepts and terms used by medical personnel who provide medical evidence, and that evolving understanding of, or recognition of, new disabling conditions is reflected.

Currently, the Rating Schedule is out of date medically. It has been more than 10 years since many body systems were comprehensively updated, and some have not been updated for much longer. The Rating Schedule should be revised to remove ambiguous criteria and obsolete conditions and language, reflect current medical practice, and include medical advances in diagnosis and classification of new conditions.

VA should expeditiously undertake a comprehensive revision of the Rating Schedule and establish a formal process to revise it approximately every 10 years. Several body systems could be revised each year on a staggered basis to make this feasible. VA will need to increase its staff capacity to update and revise the Rating Schedule. The process would also benefit from external advice from medical, rehabilitation, and vocational experts, and the veteran community.

Recommendation 4-1. VA should immediately update the current Rating Schedule, beginning with those body systems that have gone the longest without a comprehensive update, and devise a system for keeping it up to date. VA should reestablish a disability advisory committee to advise on changes in the Rating Schedule.

Revising the Rating Schedule to Improve the Relationship Between Ratings and Earnings Losses

The formal purpose of the Rating Schedule is to compensate for loss of earning capacity. Loss of earning capacity is more a legal or economic than a medical concept. In practice, the best proxy for earning capacity is actual earnings. There is no current evidence on the relationship between the Rating Schedule's severity ratings and average loss of earnings of veterans with disabilities. Findings were mixed when VA last looked at this in 1971. Since that time, substantial social and technological changes have occurred (e.g., passage of the Americans with Disabilities Act, advances in assistive devices) that make it easier for people with disabilities to work. A comparison study should be done using a nationally representative sample of veterans with and without disabilities. The rating criteria could be adjusted accordingly to achieve vertical equity (i.e., the higher the rating, the lower the earnings on average) and horizontal equity (i.e., average earnings at any given rating level are the same across conditions).

Recommendation 4-2. VA should regularly conduct research on the ability of the Rating Schedule to predict actual loss in earnings. The accuracy of the Rating Schedule to predict such losses should be evaluated using the criteria of horizontal and vertical equity.

Recommendation 4-3. VA should conduct research to determine if inclusion of factors in addition to medical impairment, such as age, education, and work experience, improves the ability of the Rating Schedule to predict actual losses in earnings.

Recommendation 4-4. VA should regularly use the results from research on the ability of the Rating Schedule to predict actual losses in earnings to revise the rating system, either by changing the rating criteria in the Rating Schedule or by adjusting the amounts of compensation associated with each rating degree.

Revising the Rating Schedule to Improve the Relationship Between Ratings and Limitations on Ability to Engage in Usual Life Activities

The lives of veterans with service-connected injuries and diseases can be changed in many ways from what their lives might have been had they not become limited by the effects of those injuries or diseases, which can affect even those veterans who can work. It is possible that the Rating Schedule, when updated, will compensate for consequences in addition to work disability even though it is intended to compensate for loss of earning capacity. This is an empirical question that VA should address by developing a functional limitation scale (or adapting an existing scale) to a sample of veterans with and without disabilities, and determining if it would lead to different ratings than would the Rating Schedule. If it is found that functional measures capture disability not captured by the Rating Schedule, VA should decide how to compensate for it.

Recommendation 4-5. VA should compensate for nonwork disability, defined as functional limitations on usual life activities, to the extent that the Rating Schedule does not, either by modifying the Rating Schedule criteria to take account of the degree of functional limitation or by developing a separate mechanism.

Revising the Rating Schedule to Improve the Relationship Between Ratings and Losses in Quality of Life

The purpose of the current Rating Schedule is to compensate for work disability, not for losses in quality of life. Therefore, it is likely that the relationship between ratings under the current Rating Schedule and the QOL measures are not particularly close, which creates an empirical question that should be addressed. If research shows a disparity between the Rating Schedule and loss of QOL measures, VA should develop a way to compensate for the loss not compensated by the Rating Schedule. This could be done by adapting the Rating Schedule to be used for both work disability and loss in quality of life, or there could be separate Rating Schedules for these two consequences of service-related injuries and diseases.

Recommendation 4-6. VA should determine the feasibility of compensating for loss of quality of life by developing a tool for measuring quality of life validly and reliably in the veteran population, conducting research on the extent to which the Rating Schedule already accounts for loss in quality of life, and if it does not, developing a procedure for evaluating and rating loss of quality of life of veterans with disabilities.

THE MEDICAL EXAMINATION AND DISABILITY RATING PROCESS

Medical Evaluation Process

Nearly every veteran applying for disability compensation is examined by a physician or other clinician (e.g., audiologist) working for or under contract to VA. Investigations of the claims process in the 1990s showed that incompleteness and lateness of such compensation and pension (C&P) examinations were a serious problem. The Veterans Benefits Administration (VBA) and the Veterans Health Administration (VHA) have worked to improve this process, but more needs to be done and stronger measures need to be taken to implement the improved procedures that have been developed.

Need for Regular Updating of Examination Worksheets/Templates

VA does not systematically update the C&P examination worksheets and some—developed as long ago as 10 years—are seriously out of date.

Recommendation 5-1. VA should develop a process for periodic updating of the disability examination worksheets. This process should be part of, or closely linked to, the process recommended above for updating and revising the Schedule for Rating Disabilities. There should be input from the disability advisory committee recommended above (see Recommendation 4-1).

Requiring the Use of the Examination Templates

Use of the worksheets is not required and many examiners do not use them. Use of the online templates has increased rapidly, presumably because of their ease of use. VA is considering a mandate that the latter be used, although that is not the case currently.

Recommendation 5-2. VA should mandate the use of the online templates that have been developed for conducting and reporting disability examinations.

Assessing and Improving Quality and Consistency of Examinations

Quality assurance of medical examinations and ratings currently is process oriented—meaning, focused on whether the information provided on the examination form was complete and timely, not whether it was correct. A sample of ratings is reviewed substantively, but the results are not systematically analyzed for general problems or consistency.

Recommendation 5-3. VA should establish a recurring assessment of the substantive quality and consistency, or inter-rater reliability, of examinations performed with the templates and, if the assessment finds problems, take steps to improve quality and consistency, for example, by revising the templates, changing the training, or adjusting the performance standards for examiners.

The Rating Process

Quality of Rating Decisions

VBA's quality assurance program, STAR, implemented in 1998, has improved the accuracy rate from 80 percent in FY 2002 to 88 percent in FY 2006. The sample is only large enough to determine the aggregate accuracy rate of regional offices. It does not assess accuracy at the body system or diagnostic code level, and it does not measure consistency across regional offices.

There are many sources of variability in decision making that, if not addressed and reduced to the extent possible, make it unlikely that veterans with similar disabilities are being treated similarly. Variability cannot be totally eliminated, but sources of variability that can be controlled, such as training, guidelines, and rater qualifications, should be addressed.

Recommendation 5-4. The rating process should have built-in checks or periodic evaluations to ensure inter-rater reliability as well as the accuracy and validity of rating across impairment categories, ratings, and regions.

Better Access to Medical Expertise

Few raters have medical backgrounds. They are required to review and assess medical evidence provided by treating physicians and VHA examining physicians and determine percentage of disability, but VBA does not have medical consultants or advisers to support the raters. Medical advisers would also improve the process of deciding what medical examinations and tests are needed to sufficiently prepare a case for rating.

Recommendation 5-5. VA raters should have ready access to qualified health-care experts who can provide advice on medical and psychological issues that arise during the rating process (e.g., interpreting evidence or assessing the need for additional examinations or diagnostic tests).

Medical consultants to adjudicators could come from VHA or outside contractors, or VBA could hire health-care providers as part of its own staff.

Training of Examiners and Adjudicators

VBA has a training program and is implementing a certification program for raters and, with VHA, is implementing a training and certification program for medical examiners. The training should be more intensive, and the training program should be rigorously evaluated.

Recommendation 5-6. Educational and training programs for VBA raters and VHA examiners should be developed, mandated, and uniformly implemented across all regional offices with standardized performance objectives and outcomes. These programs should make use of advances in adult education techniques. External consultants should serve as advisors to assist in the development and evaluation of the educational and training programs.

MEDICAL CRITERIA FOR ANCILLARY BENEFITS

Currently, VA requires a disability rating for access to other benefits that are meant to help a veteran realize his or her potential in civilian life. The process is not ideal, because it requires the veteran to establish his or her disability, which may take months or sometimes years, before he or she is eligible for benefits from available services—such as health care, vocational rehabilitation, and adaptive vehicles and housing—that could improve his or her economic situation and quality of life. There are also practical advantages to conducting a comprehensive evaluation of newly separating servicemembers that includes a determination of rehabilitation and vocational needs as well as compensation needs.

Recommendation 6-1. VA and the Department of Defense should conduct a comprehensive multidisciplinary medical, psychosocial, and vocational evaluation of each veteran applying for disability compensation at the time of service separation.

VA does not systematically assess the needs of veterans or evaluate its ancillary service programs. Many ancillary benefits, such as clothing allowances, automobile grants, and adaptive housing, arose piecemeal in response to circumstances of the time they were adopted. It could be that these programs could be changed to better serve veterans or that there are unaddressed needs. However, it is not possible to judge their appropriateness because the thresholds that have been set for ancillary benefits requirements were not based on research on who benefits or who benefits most from the services in terms of rating level.

Recommendation 6-2. VA should sponsor research on ancillary benefits and obtain input from veterans about their needs. Such research could include conducting intervention trials to determine the effectiveness of ancillary services in terms of increased functional capacity and enhanced health-related quality of life.

The current 12-year limit on eligibility for vocational rehabilitation services is a policy decision with no medical basis, although there may be administrative convenience or fiscal control reasons. There are types of employment and training requirements that do not realistically adhere to a 12-year deadline. For example, emerging assistive and workplace technologies (e.g., computing) may provide training or retraining opportunities for veterans with disabilities through continuing education of various kinds. New types of work may also emerge for which veterans with disabilities could be trained.

Recommendation 6-3. The concept underlying the extant 12-year limitation for vocational rehabilitation for service-connected veterans should be reviewed and, when appropriate, revised on the basis of current employment data, functional requirements, and individual vocational rehabilitation and medical needs.

The percentage of entitled veterans applying for vocational rehabilitation and employment (VR&E) services is relatively low. In FY 2005, about 40,000 veterans applied for VR&E services and were accepted. Of those deemed eligible, between a quarter and a third have not completed the program in recent years. VA should explore ways to increase participation in this program.

Recommendation 6-4. VA should develop and test incentive models that would promote vocational rehabilitation and return to gainful employment among veterans for whom this is a realistic goal.

INDIVIDUAL UNEMPLOYABILITY

Individual unemployability (IU) is a way for VA to compensate veterans at the 100 percent rate who are unable to work because of their service-connected disability, although their rating according to the Rating Schedule does not reach 100 percent. IU is based on an evaluation of the individual veteran's capacity to engage in a substantially gainful occupation, which is defined as the inability to earn more than the federal poverty level, rather than on the schedular evaluation, which is based on the average impairment of earnings concept.

Vocational Assessment in IU Evaluation

Currently, VA's policy is to consider vocational and other factors, but the process for obtaining and assessing vocational evaluations is weak. Raters have disability evaluation reports from medical professionals and other medical records to analyze, but they do not have comparable functional capacity or vocational evaluations from vocational experts. Raters must determine the veteran's ability to engage in normal work activities from medical reports and from information in the two-page application for IU and the one-page report from employers, neither of which asks about functional limitations. Raters do not receive training in vocational assessment.

Recommendation 7-1. In addition to medical evaluations by medical professionals, VA should require vocational assessment in the determination of eligibility for individual unemployability benefits. Raters should receive training on how to interpret findings from vocational assessments for the evaluation of individual unemployability claims.

IU Eligibility Thresholds

Currently, to be eligible for IU, a veteran must have a rating of 60 percent for one impairment or 70 percent for more than one impairment, as long as one of them is rated 40 percent. The basis for these threshold percentages is not known; they were adopted in 1941. Having a threshold makes obvious administrative sense, as long as it is not so high that many people with lower ratings who are legitimately unemployable are excluded. What that threshold should be, and the extent to which the current threshold requirements reflect actual unemployability, are not known.

Recommendation 7-2. VA should monitor and evaluate trends in its disability program and conduct research on employment among veterans with disabilities.

Age of IU Recipients

As noted in the discussion of ancillary benefits, VA does not systematically assess the economic situation of the veteran population and its needs. VA does not know, therefore, the reasons

for the rapid increase in the number of IU beneficiaries, and whether it indicates a need to address special employment or medical needs of older veterans.

Recommendation 7-3. VA should conduct research on the earnings histories of veterans who initially applied for individual unemployability benefits past the normal age of retirement for benefits under the Old Age, Survivors, and Disability Insurance Program under the Social Security Act.

Factors Considered in IU Evaluation

Congress has made a policy decision not to put an age limit on eligibility for IU. It is true that individuals are able and willing to work, and do work, into their 70s and 80s, and they should not be barred from receiving IU if disability forces them to quit. But age should still be considered a factor contributing to unemployability, in conjunction with other vocational factors that also reduce an individual's likelihood of getting or keeping a job, such as minimal education, lack of skills, and employment history (e.g., manual labor).

Recommendation 7-4. Eligibility for individual unemployability should be based on the impacts of an individual's service-connected disabilities, in combination with education, employment history, and the medical effects of that individual's age on his or her potential employability.

Employment of IU Recipients

Under the current system, a veteran on IU is permitted to engage in substantially gainful employment for up to 12 months before IU benefits are terminated, after which his or her payments drop back to their scheduler rating of 60, 70, 80, or 90 percent. Disability compensation amounts do not increase in direct proportion to disability rating percentages. The largest dollar increase in payment is between the 90 percent (\$1,483 per month) and 100 percent (\$2,471 per month) rating, which means that a veteran terminated from IU after working a year will have his or her monthly payments drop by 40 to 64 percent, depending on the scheduler rating. This poses a sudden "cash cliff" that may deter some veterans from trying to reenter the workforce. Most cash support programs try to provide incentives to work by using some sort of sliding scale to ease the transition from being a beneficiary to being ineligible.

Recommendation 7-5. VA should implement a gradual reduction in compensation to individual unemployability recipients who are able to return to substantial gainful employment rather than abruptly terminate their disability payments at an arbitrary level of earnings.

OTHER DIAGNOSTIC CLASSIFICATION SYSTEMS AND RATING SCHEDULES

Alternative Diagnostic Classification Codes

Having the same diagnostic categories for the disability compensation program as VHA and other health-care providers—*International Classification of Diseases* (ICD) and *Diagnostic and Statistical Manual for Mental Disorders* (DSM)—would facilitate communication and understanding of a veteran's health problems. The rater would be better able to relate information in medical records to the Rating Schedule if the diagnostic categories were the same. It would also help the program keep up with advances in medical understanding, because the ICD and the DSM undergo regular revision and periodic comprehensive revisions. This would help avoid the present situation in which some currently identified conditions are not in the Rating Schedule. Another advantage of using ICD codes would be the reduction in the rate of use of analogous codes.

Use of common diagnostic categories also would allow VA program managers and researchers to compare populations and trends that would help in program planning and in epidemiological and health services research. VA's diagnostic codes are unique and do not allow comparisons of trends in disabilities in populations served by VHA or the Department of Defense or research normed to the veteran population.

Recommendation 8-1. VA should adopt a new classification system using the *International Classification of Disease* (ICD) and the *Diagnostic and Statistical Manual for Mental Disorders* (DSM) codes. This system should apply to all applications, including those that are denied. During the transition to ICD and DSM codes, VA can continue to use its own diagnostic codes, and subsequently track and analyze them comparatively for trends affecting veterans and for program planning purposes. Knowledge of an applicant's ICD or DSM codes should help raters, especially with the task of properly categorizing conditions.

AMA Guides Impairment Rating System

The *AMA Guides to the Evaluation of Permanent Impairment* is superior to the current Rating Schedule in two important respects. The *Guides* uses current medical concepts, terminology, and tests, and is updated regularly; however, it is not designed to measure disability, only impairment, and it is also designed for use by physicians. The *Guides*, designed to measure degree of permanent impairment, not degree of ability to work (which is to be determined by government agencies or insurance companies), tends to have lower ratings than the Rating Schedule. The *Guides* do not determine percentage of impairment from mental disorders.

Recommendation 8-2. Considering some of the unique conditions relevant for disability following military activities, it would be preferable for VA to update and improve the Rating Schedule on a regular basis rather than adopt an impairment schedule developed for other purposes.

SERVICE CONNECTION ON AGGRAVATION AND SECONDARY BASES

Compensation for Aggravation of Preservice Disability and Allen Aggravation Claims

Determination of aggravation is an individualized clinical judgment.

Recommendation 9-1. VA should seek the judgment of qualified experts, supported by findings from current peer-reviewed literature, as guidance for adjudicating both aggravation of preservice disability and Allen aggravation claims. Judgment could be provided by VHA examiners, perhaps from VA centers of excellence, who have the appropriate expertise for evaluating the condition(s) in question in individual claims.

Secondary Service Connection

Like aggravation, secondary service connection involves individualized clinical judgment, but clinical judgment should be informed by the state of knowledge of causation in the condition being evaluated.

Recommendation 9-2. VA should guide clinical evaluation and rating of claims for secondary service connection by adopting specific criteria for determining causation, such as those cited above (e.g., temporal relationship, consistency of research findings, strength of association, specificity, plausible biological mechanism). VA should also provide and regularly update information to C&P examiners about the findings of epidemiological, biostatistical, and disease mechanism research concerning the secondary consequences of disabilities prevalent among veterans.

CONCLUSION

Some important cross-cutting themes emerged from the study. VA does not devote adequate resources to systematic analysis of how well it is providing its services (process analysis) or how much the lives of veterans are being improved (outcome analysis), the knowledge of which, in turn, would enable VA to improve the effectiveness and impacts of its benefit programs and services.

VBA does not have a program of research oriented toward understanding and improving the effectiveness of its benefit programs. Research efforts in the areas of applied process research, clinical outcomes, and economic outcomes should be undertaken.

VA is missing the opportunity to take a more veteran-centered approach to service provision across its benefits programs. VA has the services needed to maximize the potential of veterans with disabilities, but they are not actively coordinated and thus are not as effective as they could be. The disability compensation evaluation process provides an opportunity to assess the needs of veterans with disabilities for the other services VA provides, such as vocational rehabilitation, employment services, and specialized medical services. This process would coordinate VA's programs for each veteran and make it a more veteran-centered agency.

BOX S-1 Summary of Tasks and Associated Recommendations

TASK 1. *How well do the medical criteria in the VA Rating Schedule and VA rating regulations enable assessment and adjudication of the proper levels of disability to compensate both for the impact on quality of life and impairment in earnings capacity? Provide an analysis of the descriptions associated with each condition's rating level that considers progression of severity of condition as it relates to quality-of-life impairment and impairment in average earnings capacity.*

Recommendation 3-1. The purpose of the current veterans disability compensation program as stated in statute currently is to compensate for average impairment in earning capacity, that is, work disability. This is an unduly restrictive rationale for the program and is inconsistent with current models of disability. The veterans disability compensation program should compensate for three consequences of service-connected injuries and diseases: work disability, loss of ability to engage in usual life activities other than work, and loss in quality of life. (Specific recommendations on approaches to evaluating each consequence of service-connected injuries and diseases are in Chapter 4.)

Recommendation 4-1. VA should immediately update the current Rating Schedule, beginning with those body systems that have gone the longest without a comprehensive update, and devise a system for keeping it up to date. VA should reestablish a disability advisory committee to advise on changes in the Rating Schedule.

Recommendation 4-2. VA should regularly conduct research on the ability of the Rating Schedule to predict actual loss in earnings. The accuracy of the Rating Schedule to predict such losses should be evaluated using the criteria of horizontal and vertical equity.

Recommendation 4-3. VA should conduct research to determine if inclusion of factors in addition to medical impairment, such as age, education, and work experience, improves the ability of the Rating Schedule to predict actual losses in earnings.

Recommendation 4-4. VA should regularly use the results from research on the ability of the Rating Schedule to predict actual losses in earnings to revise the rating system, either by changing the rating criteria in the Rating Schedule or by adjusting the amounts of compensation associated with each rating degree.

Recommendation 4-5. VA should compensate for nonwork disability, defined as functional limitations on usual life activities, to the extent that the Rating Schedule does not, either by modifying the Rating Schedule criteria to take account of the degree of functional limitation or by developing a separate mechanism.

Recommendation 4-6. VA should determine the feasibility of compensating for loss of quality of life by developing a tool for measuring quality of life validly and reliably in the veteran population, conducting research on the extent to which the Rating Schedule already accounts for loss in quality of life, and if it does not, developing a procedure for evaluating and rating loss of quality of life of veterans with disabilities.

TASK 2. *Certain criteria and/or levels of disability are required for entitlement to ancillary and special purpose benefits. To what extent, if any, do the required thresholds need to change? Determine from a medical perspective at what disability rating level a veteran's medical or vocational impairment caused by disability could be improved by various special benefits such as adapted housing, automobile grants, clothing allowance, and vocational rehabilitation. Consideration should be given to existing and additional benefits.*

Recommendation 6-1. VA and the Department of Defense should conduct a comprehensive multidisciplinary medical, psychosocial, and vocational evaluation of each veteran applying for disability compensation at the time of service separation.

Recommendation 6-2. VA should sponsor research on ancillary benefits and obtain input from veterans about their needs. Such research could include conducting intervention trials to determine the effectiveness of ancillary services in terms of increased functional capacity and enhanced health-related quality of life.

Recommendation 6-3. The concept underlying the extant 12-year limitation for vocational rehabilitation for service-connected veterans should be reviewed and, when appropriate, revised on the basis of current employment data, functional requirements, and individual vocational rehabilitation and medical needs.

Recommendation 6-4. VA should develop and test incentive models that would promote vocational rehabilitation and return to gainful employment among veterans for whom this is a realistic goal.

TASK 3. *Analyze the current application of the Individual Unemployability (IU) extra-schedular benefit to determine whether the VASRD descriptions need to more accurately reflect a veteran's ability to participate in the economic marketplace. Propose alternative medical approaches, if any, to IU that would more appropriately reflect individual circumstances in the determination of benefits. For the population of disabled veterans, analyze the cohort of IU recipients. Examine the base rating level to identify patterns. Determine if the VASRD description of conditions provide a barrier to assigning the base disability rating level commensurate with the veteran's vocational impairment.*

Recommendation 7-1. In addition to medical evaluations by medical professionals, VA should require vocational assessment in the determination of eligibility for individual unemployability benefits. Raters should receive training on how to interpret findings from vocational assessments for the evaluation of individual unemployability claims.

Recommendation 7-2. VA should monitor and evaluate trends in its disability program and conduct research on employment among veterans with disabilities.

Recommendation 7-3. VA should conduct research on the earnings histories of veterans who initially applied for individual unemployability benefits past the normal age of retirement for benefits under the Old Age, Survivors, and Disability Insurance Program under the Social Security Act.

Recommendation 7-4. Eligibility for individual unemployability should be based on the impacts of an individual's service-connected disabilities, in combination with education, employment history, and the medical effects of that individual's age on his or her potential employability.

Recommendation 7-5. VA should implement a gradual reduction in compensation to individual unemployability recipients who are able to return to substantial gainful employment rather than abruptly terminate their disability payments at an arbitrary level of earnings.

TASK 4. *What are the advantages and disadvantages of adopting universal medical diagnostic codes rather than using a unique system? Compare and contrast the advantages/disadvantages of VA Schedule for Rating Disabilities and the American Medical Association Guides to the Evaluation of Permanent Impairment.*

Recommendation 8-1. VA should adopt a new classification system using the *International Classification of Disease (ICD)* and the *Diagnostic and Statistical Manual for Mental Disorders (DSM)* codes. This system should apply to all applications, including those that are denied. During the transition to ICD and DSM codes, VA can continue to use its own diagnostic codes, and subsequently track and analyze them comparatively for trends affecting veterans and for program planning purposes. Knowledge of an applicant's ICD or DSM codes should help raters, especially with the task of properly categorizing conditions.

Recommendation 8-2. Considering some of the unique conditions relevant for disability following military activities, it would be preferable for VA to update and improve the Rating Schedule on a regular basis rather than adopt an impairment schedule developed for other purposes.

TASK 5. *From a medical perspective, analyze the current VA practice of assigning service connection on "secondary" and "aggravation" bases. In "secondary" claims, determine what medical principles and practices should be applied in determining whether a causal relationship exists between two conditions. In "aggravation" claims, determine what medical principles and practices should be applied in determining whether a preexisting disease was increased due to military service or was increased due to the natural process of the disease.*

Recommendation 9-1. VA should seek the judgment of qualified experts, supported by findings from current peer-reviewed literature, as guidance for adjudicating both aggravation of preservice disability and Allen aggravation claims. Judgment could be provided by VHA examiners, perhaps from VA centers of excellence, who have the appropriate expertise for evaluating the condition(s) in question in individual claims.

Recommendation 9-2. VA should guide clinical evaluation and rating of claims for secondary service connection by adopting specific criteria for determining causation, such as those cited above (e.g., temporal relationship, consistency of research findings, strength of association, specificity, plausible biological mechanism). VA should also provide and regularly update information to C&P examiners about the findings of epidemiological, biostatistical, and disease mechanism research concerning the secondary consequences of disabilities prevalent among veterans.

TASK 6. *Compare and contrast the role of healthcare professionals in the claims/appeals process in VA and DoD, Social Security, and federal employee disability benefits programs. What skills, knowledge, training, and certification are required of the persons performing the examinations and assigning the ratings?*

Recommendation 5-1. VA should develop a process for periodic updating of the disability examination worksheets. This process should be part of, or closely linked to, the process recommended above for updating and revising the Schedule for Rating Disabilities. There should be input from the disability advisory committee recommended above (see Recommendation 4-1).

Recommendation 5-2. VA should mandate the use of the online templates that have been developed for conducting and reporting disability examinations.

Recommendation 5-3. VA should establish a recurring assessment of the substantive quality and consistency, or inter-rater reliability, of examinations performed with the templates and, if the assessment finds problems, take steps to improve quality and consistency, for example, by revising the templates, changing the training, or adjusting the performance standards for examiners.

Recommendation 5-4. The rating process should have built-in checks or periodic evaluations to ensure inter-rater reliability as well as the accuracy and validity of rating across impairment categories, ratings, and regions.

Recommendation 5-5. VA raters should have ready access to qualified health-care experts who can provide advice on medical and psychological issues that arise during the rating process (e.g., interpreting evidence or assessing the need for additional examinations or diagnostic tests).

Recommendation 5-6. Educational and training programs for VBA raters and VHA examiners should be developed, mandated, and uniformly implemented across all regional offices with standardized performance objectives and outcomes. These programs should make use of advances in adult education techniques. External consultants should serve as advisors to assist in the development and evaluation of the educational and training programs.

Appendix D. The Role of Medical Personnel in Selected Disability Benefit Programs.

Appendix I

Summary of *Improving the Presumptive Disability Decision-Making Process for Veterans*

The Commission contracted with the Institute of Medicine (IOM) to study the processes for deciding whether one may presume that a disability is connected to military service. IOM convened a committee of experts to perform that task; their final report is titled *Improving the Presumptive Disability Decision-Making Process for Veterans*. This appendix contains the summary from that report. The full report is available from The National Academies Press at www.nap.edu.

Summary

INTRODUCTION

The United States has long recognized and honored military veterans' service and sacrifices. Veterans injured by their service, becoming ill while in service, or having an illness after discharge as a long-term consequence of their service have been given healthcare coverage and disability compensation. As the complexity of exposures during combat has increased, the list of service-connected illnesses has grown. The Department of Veterans Affairs (VA) now provides disability compensation to approximately 2.6 million veterans for 7.7 million disabilities annually, expending approximately \$24 billion for this purpose (VBA, 2006, pp. 19, 24, 27).

Disability compensation for military veterans requires that there be a service connection. A medical illness or injury that occurred while a member was in military service is considered service connected whether caused by or aggravated by an exposure or event during service *or simply occurring coincidentally* with military service. However, if a medical condition appears after the period of military service and it is presumed to be *caused by* or aggravated by an exposure or an event that occurred during military service, then veterans may receive compensation based on that presumption (Pamperin, 2006).

In making a decision to provide compensation, VA needs to determine whether the illness of concern can generally be caused by exposures received during service and whether the illness in a specific claimant was caused by the exposure. The answer to the general question of causality comes from a careful review of all available scientific information, while the answer to the question of causation in a specific person hinges on knowledge of the exposure received by that individual and of other factors that may be relevant. If the scientific evidence is incomplete, there may be uncertainty on the question of causation generally; if there is limited or no information on exposure of individual claimants or if other factors also contribute to disease causation, there may be uncertainty on the question of individual causation.

To provide benefits to veterans in the face of these two broad types of uncertainty, Congress and VA make presumptive decisions that bridge gaps in the evidence related to causation and to exposure. Presumptions may relieve the veteran of persuading VA that the exposure produced the adverse health outcome and of proving that an exposure occurred during military service (Pamperin, 2006). Once a medical condition is service connected through presumptions, and the veteran can document military service consistent with having received the given exposure, the

veteran only has to show the basic fact that he or she suffers from the condition in order to receive a disability payment and eligibility for medical care (Zeglin, 2006).

In 2004, Congress established the Veterans' Disability Benefits Commission (the Commission), which was charged with "studying the benefits provided to compensate and assist veterans for disabilities attributable to military service" (VDBC, 2006, p. 1; as found in Appendix A). The Commission identified the presumptive disability decision-making process as a topic needing assessment and asked the Institute of Medicine (IOM) to establish a committee for this purpose that would be funded by VA. The resulting committee, the Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans (the Committee), was given the following charge by VA:

- Describe and evaluate the current model used to recognize diseases that are subject to service connection on a presumptive basis.
- If appropriate, propose a scientific framework that would justify recognizing or not recognizing conditions as presumptive.

The Commission further elaborated the charge, asking the Committee to "help ensure that future veterans are granted service connection under a presumptive basis based on the best scientific evidence available" (VDBC, 2006, p. 4; as found in Appendix A). The Commission asked the Committee to "evaluate the current model used to determine diseases that qualify for service connection on a presumptive basis, and if appropriate, propose improvements in the model" (VDBC, 2006, p. 1; as found in Appendix A). The Commission emphasized that "having a method of granting service connection quickly and fairly based on a presumption is of critical importance to our disabled veterans and their surviving spouses" and that "ensuring that future presumption processes reflect the then current medical knowledge about the causal relationship would benefit the entire veteran community" (VDBC, 2006, p. 4; as found in Appendix A). The Commission's summary statement further commented that "(t)o the extent possible, suggestions that will avoid the necessity for many future presumptions by ensuring that exposure of service members is documented and scientific evidence is made available would be important."

IOM appointed a 14-member committee that covered the broad scientific and medical areas of general, occupational, and psychiatric medicine; biostatistics; epidemiology; toxicology; industrial hygiene; and exposure and risk assessment. The Committee's members also brought expertise in law, philosophy, causal decision making, and policy as well as knowledge of the Department of Defense (DoD) and VA's approach to disability compensation.

THE COMMITTEE'S APPROACH TO ITS CHARGE

In fulfilling its charge, the Committee first investigated and attempted to characterize Congress' and VA's recent approach to presumptive disability decision-making, and then developed a conceptual framework for a new, more evidence-based process. It then constructed a way to move forward that builds on the framework and addresses deficiencies of the current process.

The Committee held three open meetings to gather information on the current presumptive disability decision-making process. The Committee heard from past and present congressional staff members, representatives of VA, DoD, IOM, various stakeholder groups (e.g., veteran service organizations [VSOs]) and the general public. Committee members also participated in conference calls with DoD experts on medical surveillance and exposure data collection and exposure assessment systems.

The Committee reviewed extensive background information including: documents provided by the Commission, public laws and supporting House and Senate reports, *Federal Register* notices, VA documents [e.g., cost estimates, a white paper on VA's decision-making processes (found in Appendix G), and responses by VA to written questions from the Committee], DoD documents, and past IOM reports commissioned by DoD and VA. The Committee conducted 10 case study reviews—mental disorders, multiple sclerosis, Prisoners of War, amputees and cardiovascular disease, radiation, Mustard Gas and Lewisite, Gulf War, Agent Orange and prostate cancer, Agent Orange and type 2 diabetes, and spina bifida (not a presumption but a VA program area)—that cover a wide variety of circumstances for which presumptions have been established by Congress and VA since 1921. The case studies were a foundation for the Committee's efforts in understanding past practices of all participants in the presumptive disability decision-making process (see Appendix I).

The Committee also researched and considered capabilities and limitations of the exposure data and health outcome information available to DoD and VA for exposure assessment, surveillance, and research purposes. The Committee examined whether DoD and VA have a strategic research plan and vision for the necessary interface between the agencies, as well as with other, relevant research organizations.

The Committee considered the use of scientific evidence in guiding the process for making presumptive decisions that affect the compensation of veterans. Drawing upon the Committee members' expertise in epidemiology, medicine, toxicology, biostatistics, and causal decision making, the Committee covered the evaluation of evidence for inferring association and causation as well as methods for quantifying the contribution of an agent to disease causation in populations and extending this quantification to individuals. Using this framework, the Committee developed an evidence-based approach for making future decisions with regard to presumptions.

THE PRESUMPTIVE DISABILITY DECISION-MAKING PROCESS FOR VETERANS

In 1921 Congress empowered the VA Administrator (now Secretary) to establish presumptions of service connection for veterans. Only Congress and the VA Secretary have the authority to establish presumptions. Over time, presumptions have been made to relieve veterans of the burden to prove that disability or illness was caused by a specific exposure which occurred during military service (e.g., Prisoners of War). Since 1921, nearly 150 health outcomes have been service connected on a presumptive basis (see Appendix F). In February 2006, Congress codified all regulatory presumptions that VA had put in place to that time.

The current presumptive disability decision-making process for veterans involves several steps and several organizations. The process involves input from many parties—Congress, VA, the National Academies, and stakeholders (e.g., VSOs, advisory committees, and individual veterans) (Figure S-1). Congress has made presumptions itself. In the current model, Congress or stakeholders acting through Congress may call on VA to assess whether a presumption is needed. The VA turns to IOM for completion of a review of the scientific evidence. The findings of that evaluation are considered by VA in its presumptive disability decision-making process. Decisions made in the courts have also influenced the current presumptive process.

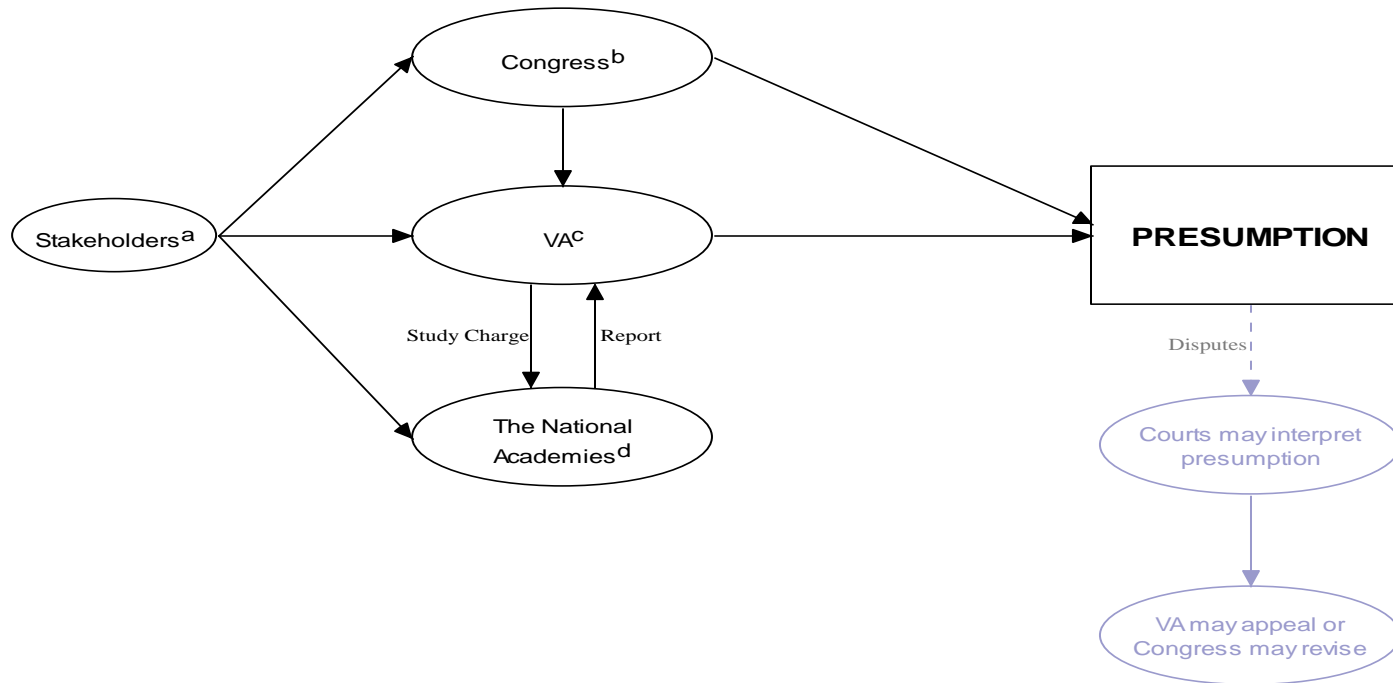


FIGURE S-1 Roles of the Participants Involved in the Presumption Disability Decision-Making Process for Veterans.

^a Stakeholders include (but are not limited to) veterans service organizations (VSOs), veterans, advisory groups, federal agencies, and the general public; these stakeholders provide input into the presumptive process by communicating with Congress, VA, and independent organizations (e.g., the National Academies).

^b Congress has created many presumptions itself; in 1921, Congress also empowered the VA Secretary to create regulatory presumptions; on several occasions in the past, Congress has directed VA to contract with an independent organization (e.g., the National Academies) to conduct studies and then use the organization’s report in its deliberations of granting or not granting regulatory presumptions.

^c VA can establish regulatory presumptions; VA sometimes contracts with the National Academies to conduct studies and uses the organization’s report in its deliberations of granting or not granting regulatory presumptions.

^d The National Academies (Institute of Medicine and National Research Council) submit reports to VA based on requests and study charges from VA.

Three major legislative actions by Congress have influenced the recent presumptive decisions—the Radiation Exposed Veterans Compensation Act of 1988 (Public Law 100-321. 100th Cong., 2d Sess.), the Agent Orange Act of 1991 (Public Law 102-4. 102d Cong., 1st Sess.), and the Persian Gulf War Acts of 1995 (Veterans' Benefits Improvement Act of 1994. Public Law 103-446. 103rd Cong., 2d Sess.) and 1998 (Making Omnibus Consolidated and Emergency Appropriations for the Fiscal Year Ending September 30, 1999, and for Other Purposes. Public Law 105-277. 105th Cong., 2d Sess.). The concept of “at least as likely as not” with regard to exposure potential was introduced for radiation exposures and its use has since been continued. The Agent Orange Act (Public Law 102-4. 102d Cong., 1st Sess.) grew out of events following the Vietnam War, and its language expresses substantial and significant elements of the presumptive story. The presumptions put in place by Congress for Gulf War illnesses represent the first time that Congress produced a list of health outcomes which it defined as “undiagnosed illnesses” (Veterans Education and Benefits Expansion Act of 2001. Public Law 107-103. 107th Cong., 1st Sess.).

When Congress enacted the Agent Orange Act of 1991 (Public Law 102-4. 102d Cong., 1st Sess.), it started a model for a decision-making process that is still in place. Congress asked VA to contract with an independent organization—VA contracted with IOM—to review the scientific evidence for Agent Orange. Since 1994, IOM has produced biennial reports on Agent Orange for VA to use as it considers making presumptive decisions (IOM, 1994, 1996, 1999, 2001, 2003b, 2005b). IOM has also delivered five volumes on the Gulf War (IOM, 2000, 2003a, 2005a, 2006, 2007). Congress requires VA to respond after receiving an IOM report with a determination as to whether VA will make a service connection for particular health outcomes on a presumptive basis. VA has described its internal decision-making processes to the Committee in a general fashion, and the Committee has reviewed VA's *Federal Register* notices and documents (see Chapter 3). However, it remains unclear to the Committee how VA makes particular determinations with regard to weighing strength of evidence for causation and exposure potential in making its presumptive decisions.

Analysis of the Agent Orange and Gulf War examples (see Appendix I) shows important similarities and differences relevant to the overall presumptive process. One difference is that Agent Orange is a single product (actually a mixture of compounds which contains the contaminant dioxin), extensively researched for associated health outcomes, whereas the health consequences of the Gulf War are unlikely to be the result of any single agent. Military service men and women may have received a number of health-relevant exposures during service in the Persian Gulf, complicating the development of evidence reviews. For Agent Orange, there is one exposure of concern and a more constrained set of health indicators. There have been some differences in approaches of Agent Orange and Gulf War committees. The IOM Agent Orange reports (IOM, 1994, 1996, 1999, 2001, 2003b, 2005b) did not explicitly include a causal category in their evaluations whereas recent Gulf War reports (IOM, 2000a, 2003a, 2005a, 2006, 2007) did include a category for evidence sufficient to infer causation when characterizing the strength of evidence for agents evaluated. For neither set of reports does VA describe in its *Federal Register* notices how it accounted for exposure potential or magnitude in making its presumptive decisions.

FINDINGS OF CASE STUDIES

The case studies offered a diverse set of lessons learned and indicated elements of the current process that need to be addressed. In carrying out the case studies, this Committee had the oppor-

tunity to retrospectively examine the work of IOM committees as they grappled with the challenge of using uncertain evidence and of VA staff as they used the findings of IOM committees to make decisions about presumptions. The case studies demonstrate that the process has acted to serve the interests of veterans in many instances. Congress and VA have repeatedly acted to maximize the sensitivity of presumptive decisions so as to assure that no veteran who might have been affected is denied compensation. On the other hand, in maximizing sensitivity of presumptive disability decision-making, substantial numbers of veterans whose illnesses may or may not have been actually service related are nonetheless compensated. There are both financial and nonfinancial costs to such decisions.

The case studies illustrate the use of presumptions to cover gaps in evidence, gaps that exist in part because of lack of information on exposures received by military personnel and inadequate surveillance of veterans for service-related illnesses. Secrecy is a particularly troubling source of incomplete information, as illustrated by the veterans who participated in studies of mustard gas and lewisite. Research carried out directly on the health of veterans has proved useful in some instances, leading to a decision, for example, on granting disability compensation for cardiovascular disease in amputees. But the research has not been systematic, and in the example of cardiovascular disease in amputees no further evidence relevant to a presumption made in 1979 has been collected. Research on radiation risks in veterans has been severely constrained by a lack of dose information, and the studies on radiation-exposed veterans have not been highly informative.

Across the case studies, the Committee found variable approaches to synthesizing evidence on the health consequences of military service. The inferential target of scientific evidence reviews has not been consistent and varied between causation (e.g., Mustard Gas and Lewisite, Gulf War) and association alone (e.g., Agent Orange). The more recent IOM Agent Orange reports have emphasized findings of observational studies on association and interpretation might have been enhanced by placing the findings within a biological framework strengthened by greater attention to other lines of evidence. In the Agent Orange case studies, the category “limited/suggestive” for classifying evidence for association has been used for a broad range of evidence from indicating the mere possibility of an association to showing that an association is possibly causal. The “limited/suggestive” evidence of association—on which the VA’s presumptive decisions to compensate type 2 diabetes and prostate cancer were made—may be below the level of certainty needed to support causation absent strong mechanistic understanding or to meet the Congressional language of “if the credible evidence for the association is equal to or outweighs the credible evidence against the association” which the Committee refers to “at least as likely as not.”

Both prostate cancer and diabetes illustrate situations in which the contribution of military exposures should be assessed against a background of disease risk that has other strong determinants: age in the case of prostate cancer and family history and obesity in the case of type 2 diabetes, as indicated by the IOM committee in its report (IOM, 2000b). For both diabetes and prostate cancer, the magnitude of the relative risks observed for pesticide exposure implies that the contribution of military exposures is likely to be small in comparison to those of the other contributing factors. In such circumstances, an estimation of the proportion of cases attributable to military exposures could be helpful to the VA in considering whether or not to presumptively service-connect disabilities. The Committee recognizes that development of such estimations is a complicated process dependent on acquiring better exposure data which may not be available for some period of time.

In the case studies, the Committee's analyses were based on the very general information provided by VA about its internal decision-making processes. The case studies and VA's decision to withhold documents related to specific decisions from the Committee did make clear, however, that these processes are not fully transparent. VA believes that access to predecisional documents by outside sources could stifle candid staff discussions on issues. Once IOM carries out its reviews and provides VA with reports documenting the extent of evidence available on associations, the internal processes of VA that follow are not fully open to scrutiny. This closed process could reduce trust of veterans in the presumptive disability decision-making process and may hinder efforts to optimize the use of scientific evidence. The Committee also found inconsistency in the decision-making process.

SCIENTIFIC FOUNDATION FOR PRESUMPTIVE DISABILITY DECISION MAKING

In developing a future approach for presumptive disability decision making, the Committee first gave extensive consideration to causal inference and the processes used to make causal judgments. In other words, the Committee considered how scientific evidence is used to determine *if* exposure causes some disease. These determinations are generally made by expert committees which examine all relevant evidence for strengths and weaknesses and then synthesize the evidence to make a summary judgment. The Committee defines "exposure" in a broad manner to include chemical, biological, infectious, physical and psychological stressors. The Committee recognizes that psychological stressors may be particularly difficult to describe, let alone measure and quantify.

The Committee then considered the quantification of the contribution of a particular exposure to disease causation. This second issue addresses the question of *how much* of the observed disease in a group, both in absolute and relative terms, is caused by the exposure.

Provision of compensation to veterans on a presumptive basis, or to any other group that has been injured, requires a *general* decision as to whether the agent or exposure of concern has the potential to cause the condition or disease for which compensation is to be provided in at least some individuals, and a *specific* decision as to whether the agent or exposure has caused the condition or disease in a particular individual. The determination of causation in general is based in a review and evaluation of all relevant evidence including: (1) data on exposures of military personnel during service, (2) evidence on risks for disease coming from observational (epidemiologic) studies of military personnel, and (3) other relevant epidemiologic evidence, including findings from studies of nonmilitary populations exposed to the agent of interest or similar agents, and (4) findings relevant to plausibility from experimental and laboratory research. The determination of causation in a particular case is based first on the general determination as to whether the exposure can cause disease, then on information about the exposures of the individual being evaluated for compensation, and on any other relevant information about the individual.

The Committee considered the properties of a decision-making process, recognizing the possibility of two types of systematic errors: making a decision to compensate when the exposure has not caused the illness (false positive) and to not compensate when the exposure has actually caused the illness (false negative). The Committee recommends that any decision process consider the trade-off between these two errors and attempt to optimize both the sensitivity (i.e., minimize the false negatives) and the specificity (i.e., minimize the false positives). Generally, higher sensitivity cannot be achieved without lower specificity. These errors have costs. False

positive errors result in the expenditure of funds for cases of disease not caused by military service while false negative errors leave deserving veterans uncompensated. The appropriate balancing of these costs also needs consideration.

The Committee considered ways to classify evidence, reaching the conclusion that a broader and more inclusive evidence review process is needed. It found that IOM reviews could be enhanced if a broader array of epidemiologic and other evidence (e.g., animal, and mechanistic data) was considered. The Committee also found that the target of inference had varied from causation (e.g., Mustard Gas / Lewisite, Gulf War) to association (e.g., Agent Orange). Consequently, the Committee recommends that categories of evidence for reviews be established to make clear those relationships that are at least as likely as not to be causal. The Committee has concluded that a categorization of evidence is needed that gives a scientifically coherent rendering of the language employed by Congress in calling for review of available scientific evidence. The Committee proposes a four-level hierarchy that classifies the strength of evidence for *causation, not just association*, and that incorporates the concept of equipoise: that is, whether the weight of scientific evidence makes causation at least as likely as not in the judgment of the reviewing group.

The Committee also gave consideration to the quantification of the burden of disease attributable to an exposure. This quantification would be made to provide an evaluation of the numbers of veterans to be compensated, but it would not be a component of the evidence evaluation for causation. For the purpose of quantification, the attributable risk, termed the *service-attributable fraction*, can be calculated if the needed information is available on the relative risk of disease among exposed individuals. For those exposures meeting the necessary level of evidence for compensation, the Committee recommends that the service-attributable fraction should be estimated overall and for subgroups of veterans, perhaps grouped by level of exposure, if the requisite data are available. Until more complete exposure information becomes available in the future, such calculations may not be possible for all conditions for which presumptions are made.

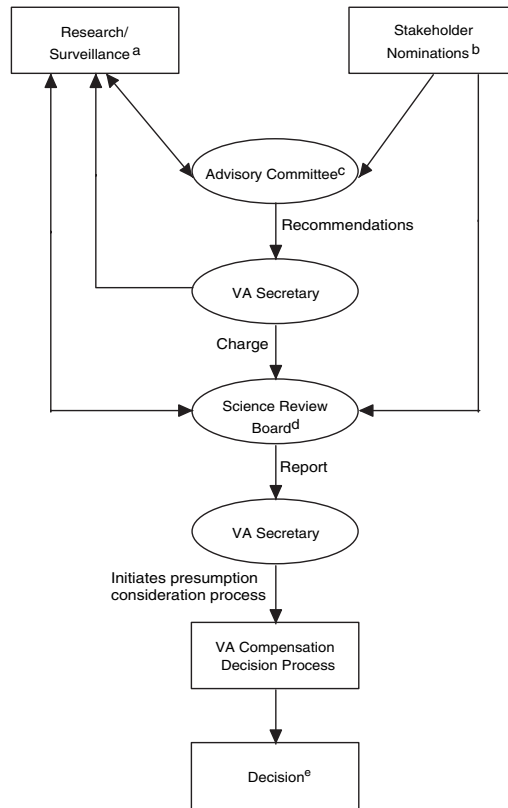
COMMITTEE'S RECOMMENDED APPROACH FOR THE FUTURE

Overview

The Committee's recommended approach for the future (Figure S-2) has multiple new elements: a process for proposing exposures and illnesses for review; a systematic evidence review process incorporating a new evidence classification scheme, and quantification of the extent of disease attributable to an exposure; a transparent decision-making process by VA; and an organizational structure to support the process. The Committee also calls for comprehensive tracking of exposures of military personnel and monitoring of their health while in service and subsequently.

Organizational Structure

The Committee recommends the creation by Congress of two new permanent boards: the Advisory Committee, serving in an advisory capacity to VA, and the Science Review Board (independent from VA). The Advisory Committee would consider the exposures and illnesses that might be a basis for presumptions and recommend to the VA Secretary exposures and illnesses needing further consideration. It would also consider research needs and assist VA with strategic research planning. The Science Review Board would evaluate the evidence for causation and, if



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FIGURE S-2 Proposed Framework for Future Presumptive Disability Decision-Making Process for Veterans.

^a Includes research for classified or secret activities, exposures, etc.

^b Includes veterans, Veterans Service Organizations, federal agencies, scientists, general public, etc.

^c This committee screens stakeholders' proposals and research in support of evaluating evidence for presumptions and makes recommendations to the VA Secretary when full evidence review or additional research is appropriate.

^d The board conducts a two-step evidence review process (see report text for further detail).

^e Final presumptive disability compensation decisions are made by the Secretary, Department of Veterans Affairs, unless legislated by Congress.

warranted, estimate the service attributable fraction of disease in veterans. One critical element in the deliberations of the Science Review Board would be evidence from monitoring the exposures and health of the veterans. The Science Review Board would provide VA with input for its presumptive decisions, including a summary report of the available scientific evidence in a standardized classification scheme.

Congress and VA may find alternative processes to achieve the overall objective of the Committee's recommendations: an evidence-based approach to making presumptive disability decisions. The Committee recognizes that specific elements of its proposal (e.g., the call for carrying out exposure assessments and making exposure estimates) are not yet fully practicable and would take time to develop and implement. However, future methodologic developments should enhance the feasibility of some of the challenging elements of this proposal. The Committee believes that this proposal can significantly improve the presumptive disability decision-making process for veterans and therefore, the process for implementing it should begin without delay.

Underlying Principles

VA's decision to make a presumption may involve weighing difficult and incomplete scientific evidence, in the context of veterans' concerns and society's obligations to the affected veterans, and potential costs. Although the potential complexity of the decision-making process may make a complete codification difficult, the underlying principles can be clearly expressed. The Committee suggests the following six principles as a foundation for its proposed framework: (1) stakeholder inclusiveness, (2) evidence-based decisions, (3) transparent process, (4) flexibility, (5) consistency, and (6) using causation, not just association, as the basis for decision making. Flexibility and consistency are not contradictory constructs here. Flexibility refers to the ability to be adaptable through time in evaluating scientific evidence, and consistency refers to being consistent in the process of evaluating evidence and making consistent decisions based on a comparable level of certainty based on the scientific evidence.

Proposals to Review for Potential Presumption

In this process, conditions and causative agents or circumstances would be proposed for review based on evidence of a connection between the condition and military service and evidence that a sizable or well-defined group of veterans is likely to be affected. The possibility of a need for a presumption might arise from surveillance of veterans or active military personnel, laboratory research discoveries, or findings from studies of exposed workers. The process would be open, with proposals accepted from any source (e.g., veterans, veterans' families, VSOs, VA, DoD, other governmental bodies, researchers, or the general public). Proposals accepted by the VA Secretary would be sent to the Science Review Board for full, comprehensive scientific evaluation.

Science Review Board

The Committee recommends a two-step process for scientific evaluation by the Science Review Board. The first step would involve a systematic review of all relevant data to decide the strength of evidence for causation, using one of four categories:

1. *Sufficient*: the evidence is sufficient to conclude that a causal relationship exists.
2. *Equipoise and Above*: the evidence is sufficient to conclude that a causal relationship is at least as likely as not, but not sufficient to conclude that a causal relationship exists.
3. *Below Equipoise*: the evidence is not sufficient to conclude that a causal relationship is at least as likely as not, or is not sufficient to make a scientifically informed judgment.
4. *Against*: the evidence suggests the lack of a causal relationship.

If the evidence for causation were categorized as *Sufficient* or at *Equipoise and Above*, then we anticipate that VA would consider a presumptive service-connection based upon causal evidence categorization and its consideration of the service attributable fraction if available (to be estimated in the second step of the process, described below). As is current VA policy, if the evidence is at *Equipoise*, the benefit of the doubt would be given to the veteran. If the evidence were categorized as *Against*, then we anticipate that VA would not consider a presumptive service-connection. If, however, the evidence were categorized as *Below Equipoise*, then we anticipate that VA would, after carefully considering the prospects and recommendations for future research, decide on an appropriate time frame for the subsequent scientific review of the evidence, with the expectation that the evidence would then be sufficient to resolve matters either for or against the causal claim at that time. Such information would be considered by the Advisory Committee serving in its capacity as overseer of the overall process and advisor to the VA Secretary.

If the VA Secretary were to decide that a presumption would not be established for evidence categorized as *Below Equipoise* or (for other reasons for evidence categorized as) *Equipoise and Above*, then during the period of further evidence development and gathering and prior to the subsequent scientific review of the evidence, VA should consider providing some support to potentially affected veterans, such as providing provisional access to medical care.

As evidence accumulates, the balance might move to strengthen or to weaken the case for causality. Importantly, the Science Review Board should be free to upgrade the level of evidence, to downgrade the level of evidence, or to leave it as the same categorization. For evidence that has reached the classification of *Sufficient*, we would not anticipate a potential lowering of the classification, if the original determination was correctly made and based on sound scientific evidence.

If the strength of the evidence reaches *Sufficient* or *Equipoise and Above*, then the evaluation would move to step two, the calculation of the service-attributable fraction of disease when required data and information are available. This calculation is independent of the classification of the strength of evidence for causation, and the magnitude of the service-attributable fraction is not considered in the application of the four-level schema for categorizing evidence. Rather, the service-attributable fraction would be of value for decision making, giving an understanding of the scope of the population to be covered by a presumption.

In step two, the Science Review Board would consider the extent of exposure among veterans and subgroups of veterans, as well as dose-response relationships. When such information is available, the board would estimate the service-attributable fraction and its related uncertainty. The purpose of step two is to convey the impact of the exposure on veterans as a whole for the purpose of decision making and planning, but not to serve inappropriately as an estimate of

probability of causation for individuals. Some exposures may contribute greatly to the disease burden of veterans, while other exposure (even with a known causal effect) may have a small impact overall. This additional information would be useful to VA in its decision making as to whether a presumption should be made for the veteran population in general, for subgroups, or not at all. In the absence of service-attributable fraction data, as will likely occur for many exposures over the short-term, we assume the VA would consider presumptions on the information contained in step one.

Expanding the Evidence Base

In the Committee's view, the best scientific decisions about presumptions can be made only with comprehensive exposure and health surveillance of military personnel. Data collection should begin on entry into the military and continue through discharge, and when harmful exposures are suspected surveillance should be extended indefinitely. Surveillance refers to the ongoing collection, analysis, and use of data relevant to the health of a population. Elements of a surveillance system are already in place, but fall short of what is required. A fully functioning surveillance system would track military exposures and health outcomes, during military service and after discharge, and maintain a repository of data and biological specimens so that emerging and unanticipated questions could be retrospectively addressed. The system needs to be seamless in following military personnel, including National Guard and reservists, from active duty as they transition and become civilians.

This surveillance system should also track job and deployment history for each soldier through the period of service, with exposure assessment and monitoring for a range of job categories. Information on disease risk factors more generally could also be tracked. Use of personal biological samples for individual monitoring also holds promise.

Assessing exposures relevant to the neuropsychiatric disorders that are frequent among veterans of recent and current combats is particularly problematic. Documentation of stress is requisite to the diagnosis of posttraumatic stress disorder (PTSD), but approaches for capturing exposures to such stressors and to the circumstances of combat have not yet been developed and put into place. Research is needed for this purpose that builds on existing approaches so that data become available over the long-term.

In addition to surveillance, the Committee recommends an effort to coordinate and focus research on the health effects of military exposures. Associations identified in the surveillance data might need follow-up through more focused epidemiologic studies or exposure assessments. Toxicological research might be indicated to explore the mechanistic basis for an association between an exposure and a health condition.

VA Procedures

Ultimately, the decision regarding which proposed topics for potential presumptions deserve full evaluation resides with VA. In the Committee's proposed process, VA also receives scientific input from the Science Review Board. We recommend that VA establish a uniform and transparent process for making decisions regarding presumptions following receipt of evidence reviews. VA should establish procedures with input from the many stakeholders, and a clear, evidence-based rationale should be offered for all decisions. The Committee's recommendations that follow are aimed at providing a sound scientific framework for the presumptive disability decision-making process. The Committee clearly recognizes that there are social, economic, political, and legal factors beyond the scope of scientific evidence that may influence the presump-

tive disability decision-making process for veterans and the presumptive decisions which are established by Congress and VA.

Scientific evidence is not static, and it often is less than certain. Given that the scientific basis for presumptive decisions will change over time, the Committee recommends that VA should be able to adjust future decisions when such change is scientifically justified. This does not mean that the Committee recommends that benefits previously granted should be terminated. The Committee is aware that disabled veterans and their families are often dependent on such payments and that it could create a hardship to remove them, a matter which VA disability policy recognizes in other situations.

SPECIFIC RECOMMENDATIONS

Based on its evaluation of the current process for establishing presumptive disability decisions and its consideration of alternatives, the Committee has specific recommendations for an approach that would build stronger scientific evidence into the decision-making process and, at the same time, be even more responsive and open to veterans. We propose a transformation of the current presumptive disability decision-making process. We recognize that considerable time would be needed to implement some of these recommendations as would additional investment to create systems needed to track exposures and health status of currently serving military service personnel and veterans. Progress depends on greater research capacity and improvements in the evaluation and utilization of scientific evidence in making compensation decisions. We find that there are elements of the current process that could be changed quickly and we recommend that VA consider prompt action as it moves toward implementation of a new approach. The recommendations that follow are based around the Committee's proposed framework for making presumptive decisions. We list the recommendations in relation to the appropriate body.

Congress

Recommendation 1. Congress should create a formal advisory committee (Advisory Committee) to VA to consider and advise the VA Secretary on disability-related questions requiring scientific research and review to assist in the consideration of possible presumptions.

Recommendation 2. Congress should authorize a permanent independent review body (Science Review Board) operating with a well-defined process which will use evaluation criteria as outlined in this Committee's recommendations to evaluate scientific evidence for VA's use in considering future service-connected presumptions.

Department of Veterans Affairs

Recommendation 3. VA should develop and publish a formal process for consideration of disability presumptions that is uniform and transparent and which clearly sets forth all evidence considered and the reasons for the decisions reached.

Science Review Board

The recommendations that follow are directed towards the proposed, future Science Review Board, the entity to be established in the Committee's proposed approach.

Recommendation 4. The Committee recommends that the goal of the presumptive disability decision-making process be to ensure compensation for veterans whose diseases are *caused by military service* and that this goal must serve as the foundation for the work of the Science Review Board. The Committee recommends that the Science Review Board implement its proposed 2-step process.

Recommendation 5. The Committee recommends that the Science Review Board use the proposed four-level classification scheme, as follows, in the first step of its evaluation. The Committee recommends that a standard be adopted for "causal effect" such that if there is at least as much evidence in favor of the exposure having a causal effect on the frequency or severity of disease as there is evidence against, then a service-connected presumption will be considered.

1. *Sufficient*: the evidence is sufficient to conclude that a causal relationship exists.
2. *Equipose and Above*: the evidence is sufficient to conclude that a causal relationship is at least as likely as not, but not sufficient to conclude that a causal relationship exists.
3. *Below Equipose*: the evidence is not sufficient to conclude that a causal relationship is at least as likely as not, or is not sufficient to make a scientifically informed judgment.
4. *Against*: the evidence suggests the lack of a causal relationship.

Recommendation 6: The Committee recommends that a broad spectrum of evidence, including epidemiologic, animal, and mechanistic data, be considered when evaluating causation.

Recommendation 7. When the causal evidence is at Equipose and Above, the Committee recommends that an estimate also be made of the size of the causal effect among those exposed.

Recommendation 8. The Committee recommends that, as the second part of the 2-step evaluation, the relative risk and exposure prevalence be used to estimate an attributable fraction for the disease in the military setting (i.e., service-attributable fraction).

Department of Defense and Department of Veterans Affairs

The following recommendations are intended to improve the evidence on exposures and health status of veterans:

Recommendation 9. Inventory research related to the health of veterans, including research funded by DoD and VA, and research funded by the National Institutes of Health and other organizations.

Recommendation 10. Develop a strategic plan for research on the health of veterans, particularly those returning from conflicts in the Gulf and Afghanistan.

Recommendation 11. Develop a plan for augmenting research capability within DoD and VA to more systematically generate evidence on the health of veterans.

Recommendation 12. Assess the potential for enhancing research through record linkage using DoD and VA administrative and health record databases.

Recommendation 13. Conduct a critical evaluation of Gulf War troop tracking and environmental exposure monitoring data so that improvements can be made in this key DoD strategy for characterizing exposures during deployment.

Recommendation 14. Establish registries of soldiers and veterans based on exposure, deployment, and disease histories.

Recommendation 15. Develop a plan for an overall integrated surveillance strategy for the health of soldiers and veterans.

Recommendation 16. Improve the data linkage between the electronic health record data systems used by DoD and VA—including capabilities for handling individual soldier exposure information that is included as part of the individual's health record.

Recommendation 17. Ensure implementation of the DoD strategy for improved exposure assessment and exposure data collection.

Recommendation 18. Develop a data interface that allows VA to access the electronic exposure data systems used by DoD.

Recommendation 19. DoD and VA should establish and implement mechanisms to identify, monitor, track, and medically treat individuals involved in research and other activities that have been classified and are secret.

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Appendix J

Summary of *Posttraumatic Stress Disorder: Diagnosis and Assessment*

The Commission examined the reports of two studies that the Institute of Medicine conducted for the Department of Veterans Affairs on posttraumatic stress disorder in service members and veterans. This appendix contains the summary from the first of those reports, *Posttraumatic Stress Disorder: Diagnosis and Assessment*. The full report is available from The National Academies Press at www.nap.edu.

SUMMARY

In response to growing national concern about the number of veterans who might be at risk for posttraumatic stress disorder (PTSD) as a result of their military service, the Department of Veterans Affairs (VA) asked the Institute of Medicine (IOM) to conduct a study on the diagnosis and assessment of, and treatment and compensation for PTSD. An existing IOM committee, the Committee on Gulf War and Health: Physiologic, Psychologic and Psychosocial Effects of Deployment-Related Stress, was asked to conduct the diagnosis, assessment, and treatment aspects of the study because its expertise was well-suited to the task. The committee was specifically tasked to “review the scientific and medical literature related to the diagnosis and assessment of PTSD, and to review PTSD treatments (including psychotherapy and pharmacotherapy) and their efficacy.” In addition, the committee was given a series of specific questions from VA regarding diagnosis, assessment, treatment, and compensation. The questions pertaining to diagnosis and assessment and the committee’s responses are provided in Appendix A. This report is a brief elaboration of the committee’s responses to VA’s questions, not a detailed discussion of the procedures and tools that might be used in the diagnosis and assessment of PTSD.

The committee decided to approach its task by separating diagnosis and assessment from treatment and preparing two reports. This first report focuses on diagnosis and assessment of PTSD. Given VA’s request for the report to be completed within 6 months, the committee elected to rely primarily on reviews and other well-documented sources. A second report of this committee will focus on treatment for PTSD; it will be issued in December 2006. A separate committee, the Committee on Veterans' Compensation for Post Traumatic Stress Disorder, has been established to conduct the compensation study; its report is expected to be issued in December 2006.

CHARACTERISTICS OF POSTTRAUMATIC STRESS DISORDER

PTSD is a psychiatric disorder that can develop after the direct, personal experiencing or witnessing of a traumatic event, often life-threatening. The essential characteristic of PTSD is a cluster of symptoms that include:

- Re-experiencing—intrusive recollections of a traumatic event, often through flashbacks or nightmares,
- Avoidance or numbing—efforts to avoid anything associated with the trauma and numbing of emotions,
- Hyperarousal—often manifested by difficulty in sleeping and concentrating and by irritability.

If those symptoms last for a month or less, they might be indicative of acute stress disorder; however, for a diagnosis of PTSD to be made, the symptoms must be present for at least a month and must cause “clinically significant distress and/or impairment in social, occupational, and/or other important areas of functioning.”

CURRENT DIAGNOSTIC CRITERIA

Although there is a long history of descriptions of posttraumatic syndromes, the modern era of diagnosing PTSD began in 1980 with the introduction of PTSD in the third edition of APA *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*. Formal recognition of PTSD led to a large body of systematic research on its features and research findings led to modification and refinement of the diagnostic criteria. But many of the diagnostic criteria from *DMS-III* are largely unchanged in the latest revision of the fourth edition of the diagnostic manual, *DSM-IV-TR* (hereafter referred to as the *DSM-IV*).

The evidence-based diagnosis of PTSD, according to *DSM-IV* (see Box 2.1) has several components: exposure to a traumatic event, intrusive re-experiencing of the event, avoidance and numbing, hyperarousal, duration of symptoms for at least a month, and clinically significant distress or impairment that was not present before the trauma.

CLINICAL DIAGNOSIS AND ASSESSMENT

Numerous traumatic events or stressors are known to influence the onset of PTSD; however, not everyone who experiences a traumatic event or stressor will develop PTSD. Its development depends on the intensity of the traumatic event or stressor and on a host of risk and protective factors occurring before, during, and after the trauma.

After a traumatic event, there is substantial variation among patients with regard to both the timing of the onset of symptoms and the types of symptoms. Furthermore, there might be a delay between the onset of symptoms and when the patient seeks help. Patients also vary in how they present to a health professional. For example, a patient might present at a health facility with a physical or psychiatric complaint unrelated to PTSD, and it is only during the course of evaluating or treating the patient for the presenting complaint that symptoms of PTSD can be identified and a diagnosis made. In other cases, a patient might present to a mental health professional who is conversant with the diagnosis of PTSD and is better able to elicit a narrative of exposure and symptoms; or a family member or other person familiar with the veteran might seek advice from a health professional about coping with a veteran who might be suffering from PTSD. The presenting symptoms and initial diagnostic process are variable and might necessitate a brief or long assessment.

Optimally, a patient is evaluated in a confidential setting with a face-to-face interview by a health professional experienced in the diagnosis of psychiatric disorders, such as a psychiatrist, psychologist, clinical social worker, or psychiatric nurse. The interview should elicit the patient's symptoms, assess the history of potentially traumatic events, determine whether the patient meets the *DSM-IV* criteria for PTSD, determine the frequency and severity of symptoms and the associated disability, and determine whether there are comorbid psychiatric and medical conditions. It is critical that adequate time be allocated for this assessment. Depending on the mental and physical health of the veteran, the veteran's willingness and capacity to work with the health professional, and the presence of comorbid disorders, the process of diagnosis and assessment will likely take at least an hour and could take many hours to complete.

Unfortunately, many health professionals do not have the time or experience to assess psychiatric disorders adequately or are reluctant to attribute symptoms to a psychiatric disorder. Furthermore, veterans with PTSD might not present to a mental health professional, because they do not attribute their symptoms to a psychiatric disorder, they feel that a stigma is associated with psychiatric illness, they have limited access to such professionals, or for other reasons, such as cost. Therefore, health professionals should be aware that veterans, especially those who have

served in war theaters, are at risk for the development of PTSD, but might present with physical or psychiatric complaints that are symptomatic of substance use disorder or other psychiatric conditions. Health professionals should ask all veterans about possible exposure to potentially traumatic events.

A basic component in diagnosing PTSD is determining whether a person has experienced a traumatic event that has led to symptoms indicative of PTSD (see criterion A in Box 2.1). A war environment is rife with opportunities for exposure to traumatic events of many types. Types of traumatic stressors related to war include serving in dangerous military roles, such as driving a truck at risk for encountering roadside bombs, patrolling the streets, and searching homes for enemy combatants, suicide attacks, sexual assaults or severe sexual harassment, physical assault, duties involving graves registration, accidents causing serious injuries or death, friendly fire, serving in medical units, killing or injuring someone, seeing someone being killed, injured, or tortured, and being taken hostage.

ASSESSMENT INSTRUMENTS

The most important consideration in diagnosing PTSD is a systematic, comprehensive approach to obtaining a patient's clinical history in a face-to-face, confidential diagnostic interview. Structured and semi-structured approaches to diagnosing PTSD are also useful, especially in epidemiologic and treatment-outcomes research. Some of the most widely used interview instruments for diagnosing PTSD are the Clinician-Administered PTSD Scale (CAPS), the Structured Clinical Interview for DSM-IV, the PTSD Symptom Scale–Interview Version, the Structured Interview for PTSD, the Diagnostic Interview Schedule IV, and the Composite International Diagnostic Interview.

Structured interviews such as the CAPS, which were developed specifically for diagnosis of PTSD, might take an hour or more to administer, although others, such as the PSS-I, can take less time. There are also several self-report instruments that can be used to help document symptoms and traumatic exposures. These include the Posttraumatic Diagnostic Scale, the Davidson Trauma Scale, and the Detailed Assessment of Posttraumatic Stress (DAPS). Each of the instruments determines what symptoms of PTSD are present, as well as their frequency and intensity.

Although numerous instruments have been developed for the diagnosis and assessment of PTSD, the committee strongly concludes that the best way to determine whether a person is suffering from PTSD is with a thorough, face-to-face clinical interview by a health professional trained in diagnosing psychiatric disorders. Such a health professional will be familiar with the *DSM-IV* criteria for PTSD (which the committee finds are appropriate for diagnosing PTSD) and will use those criteria when diagnosing patients.

Appendix K

Summary of *PTSD Compensation and Military Service*

The Commission examined the reports of two studies that the Institute of Medicine conducted for the Department of Veterans Affairs on posttraumatic stress disorder in service members and veterans. This appendix contains the summary from the second of those reports, *PTSD Compensation and Military Service*. The full report may be obtained from The National Academies Press at www.nap.edu.

Summary

The scars of war take many forms: the limb lost, the illness brought on by a battlefield exposure, and, for some, the psychological toll of encountering an extreme traumatic event. The mission of the Department of Veterans Affairs (VA) “to care for him who shall have borne the battle” is met through a series of benefits programs for veterans and their dependents. One of these programs—the provision of compensation to veterans whose disability is deemed to be service-connected—has risen in public prominence over the past few years. While several factors have contributed to this development, three that have received particular notice are the increase in the number of veterans seeking and receiving benefits, the concomitant increase in benefits expenditures, and the prospect of a large number of veterans of Operation Iraqi Freedom and Operation Enduring Freedom entering the system.

Compensation claims for posttraumatic stress disorder (PTSD) have attracted special attention. PTSD, in brief, is a psychiatric disorder that can develop in a person who experiences, witnesses, or is confronted with a traumatic event, often one that is life-threatening. PTSD is characterized by a cluster of symptoms that include:

- reexperiencing—intrusive recollections of a traumatic event, often through flashbacks or nightmares;
- avoidance or numbing—efforts to avoid anything associated with the trauma and numbing of emotions; and
- hyperarousal—often manifested by difficulty in sleeping and concentrating and by irritability.

A 2005 investigation by the VA Office of the Inspector General found that the number of beneficiaries receiving compensation for PTSD increased significantly during Fiscal Years 1999–2004, growing by 79.5 percent, from 120,265 to 215,871 cases (DVA, 2005). The report of that investigation noted:

During the same period, PTSD benefits payments increased 148.8 percent from \$1.72 billion to \$4.28 billion. Compensation for all other disability categories only increased by 41.7 percent. While veterans being compensated for PTSD represented only 8.7 percent of all claims, they received 20.5 percent of all compensation benefits.

Against this backdrop, VA's Veterans Benefits Administration (VBA) asked the National Academies to convene a committee of experts to address several issues surrounding its administration of veterans' compensation for PTSD.

INTENT AND GOALS OF THE STUDY

The committee was charged with reviewing:

1. VA's compensation practices for PTSD, including examining the criteria for establishing severity of PTSD as published in the Schedule for Rating Disabilities;
2. the basis for assigning a specific level of compensation to specific severity levels and how changes in the frequency and intensity of symptoms affect compensation practices for PTSD;
3. how VA's compensation practices and reevaluation requirements for PTSD compare with those of other chronic conditions that have periods of remission and return of symptoms; and
4. strategies used to support recovery and return to function in patients with PTSD¹ (Szybala, 2006).

These four general charges were operationalized into a series of issues that VA identified as being of particular interest. The committee organized these into three general categories: those related to the PTSD compensation and pension (C&P) examination, the evaluation of PTSD disability claims, and other PTSD compensation issues.

REPORT SYNOPSIS

The committee reached a series of findings and conclusions that form the foundation for its recommendations for action and further research. In addition, it drew some general observations from its examination of VA's PTSD disability compensation system. The sections below are synopses of the content of report Chapters 4–7 and highlight their major points.

The PTSD Compensation and Pension Examination

For veterans presenting for PTSD compensation, the C&P examination provides a clinical evaluation by a mental health professional where information is gathered to:

- establish the presence or absence of a diagnosis of PTSD;
- determine the severity of PTSD symptoms; and
- establish a logical relationship between exposure to military stressors and current PTSD symptomatology (VBA, 2002).

¹ A separate National Academies committee is addressing PTSD treatment issues; its report will be released later in 2007. This report limits its review of the topic to the effect of compensation on strategies used to support recovery and return to function in patients with PTSD.

While it develops much of the same information as a conventional mental-health examination, the intent of the C&P examination is to generate documentation for disability evaluation purposes rather than to inform a treatment strategy.

VA identified several issues related to the conduct of C&P exams that were of particular interest: the role of the Global Assessment of Functioning (GAF) score² in evaluating PTSD; the division of symptoms among PTSD and comorbid disorders; the value of standardized testing in the conduct of examinations; and the scientific literature regarding the length of time between the occurrence of the stressor thought to be associated with an applicant's PTSD and the appearance of symptoms.

The committee concluded that the GAF score has limited usefulness in the assessment of the level of disability for PTSD compensation. The score is only marginally applicable to PTSD because of its emphasis on the symptoms of mood disorder and schizophrenia and its limited range of symptom content. The social and functional domains of the score provide some information, but if these are the sole domains of interest, better measures of them exist. Importantly, the GAF has not to date been shown to have good psychometric properties (i.e., good reliability) within the VA system and, particularly, within samples of veterans suffering from PTSD.

Because the GAF is widely used within VA, it may not be possible to quickly implement changes regarding it without disrupting the delivery of PTSD services. Given this, the committee recommends that, in the short term, VA ensure that its mental-health professionals are well informed about the uses and limitations of the GAF and—to the extent possible—are trained to implement the GAF in a consistent and uniform manner. VA should also provide periodic, mandatory retraining to minimize drift and variation in scoring over time and between facilities. In the longer term, the committee recommends that VA identify and implement an appropriate replacement for the GAF: one or more measures that focus on the symptoms of PTSD used to define the disorder and on the other domains of disability assessment.

PTSD is marked by high rates of comorbidity. Some studies have found that more than 80 percent of people who have a diagnosis of PTSD also have major depressive disorder or some other psychiatric disorder. This presents a challenge for the VA disability system, which is built around the separate evaluation and compensation of each diagnosed service-connected disorder. The committee did not identify any scientific literature on separating the symptoms of PTSD from those of another existing mental disorder. Such separation—while required by the C&P system—is seldom useful from a clinical perspective. Clinicians are often able to offer an informed opinion on this question, but this is a professional judgment and not an empirically testable finding. To ameliorate the difficulties encountered in dealing with situations where PTSD co-exists with other mental disorders, the committee recommends that a standardized training program be developed for clinicians conducting compensation and pension psychiatric evaluations. This training program should emphasize diagnostic criteria for PTSD and comorbid conditions with overlapping symptoms as delineated in the *DSM* and include example cases that illustrate appropriate documentation of exam results for C&P purposes.

A number of psychological tests have been developed to assess PTSD; some have been designed specifically for veterans and subjected to research to assess their psychometric properties. The committee responsible for the 2006 Institute of Medicine (IOM) report *PTSD: Diagnosis and Assessment* concluded that while standardized testing of veterans presenting with

² The GAF score is a standardized measure of symptoms and psychosocial function, with 100 representing superior mental health and psychosocial function and 0 representing the worst possible state.

possible PTSD may be useful in identifying individuals who might benefit from further assessment, it was not a substitute for a thorough clinical evaluation by an experienced mental health professional. This committee concludes that this is also true of testing for compensation and pension purposes. It understands the appeal of an administratively straightforward requirement that certain psychological tests be applied across the board in PTSD C&P examinations. However, this strategy does not recognize the diversity of the claimant population, and it imbues test results with an inappropriate level of certainty. Malingering—an issue that has received some public attention—cannot be reliably identified through testing alone. The committee believes that testing may be a useful adjunct to the PTSD C&P examination but recommends that the choice of whether to test and which tests are appropriate be left at the discretion of the clinician, the person who is best able to evaluate the individual circumstances of the case.

Because some veterans who have been separated from service for an extended period of time have filed first-time claims for PTSD compensation, interest has arisen in issues concerning the time between exposure to a stressor and the appearance of symptoms related to it. The committee's review found abundant scientific evidence indicating that PTSD can develop at any time after exposure to a traumatic stressor, including cases where there is a long time interval between the stressor and the recognition of symptoms. Some of these cases may involve the initial onset of symptoms after many years of symptom-free life, while others may involve the manifestation of florid symptoms in persons with previously undiagnosed subclinical or subsyndromal PTSD. The determinants of delayed-onset PTSD are not well understood. It is hypothesized that the impact of the aging process on neurologic and mental state, changes in social circumstances (retirement, loss of spouse, and the like), changes in health circumstances (disease onset or exacerbation), and exposure to other stressors may all play roles. The scientific literature does not identify any differences material to the consideration of compensation between these delayed-onset or delayed-identification cases and those chronic PTSD cases where there is a shorter time interval between the stressor and the recognition of symptoms.

Summary Findings and Conclusions

The GAF score has limited usefulness in the assessment of the level of disability for PTSD compensation.

There is no scientific guidance addressing the separation of symptoms of comorbid mental disorders for the purpose of identifying their relative contributions to a subject's condition.

Standardized psychological testing of claimants may be a useful adjunct to the PTSD C&P examination but it is not a substitute for a thorough clinical evaluation.

PTSD can develop at any time after exposure to a traumatic stressor. The scientific literature does not identify any differences material to the consideration of compensation between delayed-onset or delayed-identification cases and those chronic PTSD cases where there is a shorter time interval between the stressor and the recognition of symptoms.

Summary Recommendations

In the short term, VA should ensure that its mental-health professionals are well informed about the uses and limitations of the GAF and trained to implement it in a consistent and uniform manner. In the longer term, VA should identify and implement an appropriate replacement for the GAF. The research needed to accomplish this effort should be facilitated.

A standardized training program should be developed for clinicians conducting C&P evaluations for PTSD. Training should emphasize diagnostic criteria and comorbid conditions with overlapping symptoms, and include example cases that illustrate appropriate documentation of exam results for C&P purposes.

The choice of whether to conduct psychological testing of claimants and of which tests are appropriate should be left at the discretion of the examining clinician.

The Evaluation of PTSD Disability Claims

Information developed in the C&P claims and examination process is used by VBA personnel informally referred to as *raters* to determine whether an identified disability is connected to a claimant's military service and, if it is, what level of impairment is associated with it. Raters use criteria and decision rules set out in the VA Schedule of Rating Disabilities (VASRD) to make their decisions.

VA asked the committee to address several issues related to the rating criteria currently used to rate disability for veterans with service-connected PTSD. These included whether the current rating schedule—which applies to all mental disorders—is appropriate for evaluating PTSD and what criteria should be included in any revised schedule. The committee also offered comments on the training of raters.

38 CFR §4.130 sets out a single set of rating criteria for all mental disorders except eating disorders. The committee found that these criteria are at best a crude and overly general instrument for the assessment of PTSD disability, and it recommends that rating criteria specific to PTSD and based on the *DSM* be developed. It is beyond the scope of this committee to specify the criteria and disability levels, but the committee does offer a framework for establishing them. The primary element that distinguishes this framework from the current rating criteria is that it takes a multidimensional approach. In the current scheme, occupational impairment drives the determination of the rating level. Under the committee's framework, the psychosocial and occupational aspects of functional impairment would be separately evaluated, and the claimant would be rated on the dimension on which he or she is more affected. The committee believes that the emphasis on occupational impairment in the current criteria unduly penalizes veterans who may be symptomatic or impaired in other dimensions but capable of working, and thus it may serve as a disincentive to both work and recovery.³ While impairment of earning capacity is specified as the criterion for establishing ratings and this would seem to suggest that a focus on occupational function is appropriate, there is abundant evidence that both VA and the Congress

³ A *21st Century System for Evaluating Veterans for Disability Benefits* (IOM, 2007) addresses the more general issues of how VA should conceptualize disability for rating purposes and how system-wide revisions to the rating schedule should be implemented.

take other criteria into account when setting ratings policy. The committee believes that it is appropriate to apply this broader approach to PTSD ratings.

While the committee was able to obtain some data on the characteristics of PTSD beneficiaries and the details of their compensation over time, other information that would have helped inform the committee's evaluations were not available. To address these data gaps, the committee recommends that data fields recording the application and reevaluation of benefits should be preserved over time, rather than being overwritten when final determinations are made, and that they be gathered and coded at two points in the process where there is currently little information available: before claims are made, and after compensation decisions are rendered. Data such as these will facilitate more informed future analyses of PTSD disability compensation issues.

PTSD can be a chronic condition that may exhibit periods of remission and return of symptoms. It and other conditions characterized by remitting and relapsing symptoms present a challenge for raters because it can be difficult to assign a level of disability to them. Moreover, the absence of disabling symptoms does not mean that the subject is free from the effects of the disorder. The committee found that the criteria used for rating remitting/relapsing conditions vary in how the frequency and effect of symptoms are factored, in whether response to treatment is considered, in the level of disability assigned to various degrees of impairment, and in whether nonoccupational impacts are addressed. As noted above, PTSD is managed differently from other conditions in that it is subject to the general mental disorders ratings schedule rather than a specific set of criteria, and the committee recommends that this be changed.

Determining ratings for mental disabilities in general and for PTSD specifically is more difficult than for many other disorders because of the inherently subjective nature of symptom reporting. In order to promote more accurate, consistent, and uniform PTSD disability ratings, the committee recommends that VA establish a specific certification program for raters who deal with PTSD claims, with the training to support it, as well as periodic recertification. PTSD certification requirements should be regularly reviewed and updated to include medical advances and to reflect lessons learned. The program should provide specialized training on the psychological and medical issues (including common comorbidities) that characterize the claimant population, and guidance on how to appropriately manage commonly-encountered ratings problems. The committee believes that rater certification will foster greater confidence in ratings decisions and in the decision-making process. Requiring certification may also necessitate that some ratings be done at a facility other than the one closest to the veteran in order to ensure that a qualified rater performs the evaluation in a timely manner. VA therefore needs to manage reviews by certified raters in a manner that facilitates open communications between clinicians, remote raters, and other dispersed personnel and ensures that the claimants and those who help them are not disadvantaged.

Summary Findings and Conclusions

The VASRD criteria for rating mental disorders disability levels are at best a crude and overly general instrument for the assessment of PTSD disability.

The VASRD does not use consistent criteria for rating remitting/relapsing conditions. PTSD is managed different from other remitting/relapsing conditions because it is subject to a general ratings schedule rather than a specific set of criteria.

Summary Recommendations

New VASRD rating criteria specific to PTSD and based on the *DSM* should be developed and implemented. A multidimensional framework for characterizing PTSD disability—detailed in the body of this report—should be considered when formulating these criteria.

VA should establish a specific certification program for raters who deal with PTSD claims, with the training to support it and periodic recertification.

Data fields recording the application and reevaluation of benefits should be preserved over time rather than being overwritten when final determinations are made. Data should also be gathered at two points in the process where there is currently little information available: before claims are made and after compensation decisions are rendered.

Other PTSD Compensation Issues

The committee also addressed some compensation issues that were not specific to the C&P examination or the rater's evaluation but instead entailed broader considerations. These broader considerations include barriers or disincentives to recovery, the effect of disability compensation on recovery, the advisability of periodic reexamination of PTSD compensation beneficiaries, and gender and military assault.

Research reviewed by the committee indicates that compensation does not in general serve as a disincentive to seeking treatment. Because PTSD may follow a remitting/relapsing course, the definition of "recovery" is problematic. The literature on recovery indicates that it is influenced by several factors, and the independent effect of compensation on recovery is difficult to disentangle from these. As noted above, the committee believes that the rating criteria for PTSD should be changed to remove the focus on occupational impairment from the definition of the higher levels of disability because this may remove a disincentive for some to engage in work. The committee recommends that VA consider instituting a set long-term minimum level of benefits⁴ that would be available to any veteran with service-connected PTSD at or above some specified rating level without regard to that person's state of health at a particular point in time after the C&P examination. Providing a guaranteed minimum level of benefits would take explicit account of the remitting/relapsing nature of chronic PTSD by providing a safety net for those who might be asymptomatic for periods of time. A properly designed set of benefits could eliminate uncertainty over future timely access to treatment and financial support in times of need and would in part remove the incentive to "stay sick" that some suggest is a flaw of the current system. However, any such change in policy would require careful study of a number of factors, including the needs of the beneficiaries, the new incentives that it would create, its possible effect on compensation outlays and demand for other VA resources, the maintenance of fairness with other conditions that have a remitting/relapsing nature, and the program details—which benefits were made available and under what circumstances—that would be most likely to promote wellness.

Neither federal regulation nor published VA materials offers advice to raters on how often or under what circumstances reevaluations of PTSD disability should take place. The committee

⁴ In this context, "benefits" comprise the full range of services provided by VA, including forms of assistance such as preferred access to VA medical facilities. It does not necessarily mean a long-term minimum rating or level of compensation.

recommends that this determination be made on a case-by-case basis using information developed in a clinical setting, such as a C&P examination. It recommends that specific guidance on the criteria for setting case-specific VA-initiated reevaluations be established so that the reevaluations can be administered in a fair and consistent manner; furthermore, VBA should collect and analyze data on VA and veteran-initiated reevaluations so that the system can be improved in the future. The committee does not believe it is appropriate to mandate across-the-board periodic reexaminations for beneficiaries already being compensated for PTSD. Such a strategy would not take the diversity of the beneficiary population into account and would unduly single out veterans with PTSD for scrutiny. Within the context of VA's limited resources, the committee believes that it would be best to invest in thorough C&P evaluations for new applicants—including the clinician's determination noted above—rather than in the blanket review of past decisions.

Available research suggests that female veterans are less likely to receive service connection for PTSD and that this may be a consequence of the relative difficulty of substantiating exposure to non-combat traumatic stressors—notably, military sexual assault (MSA). The committee believes that it is important to gain a better understanding of the sources of this disparity and to better facilitate the substantiation of MSA-related traumas in both women and men when they do occur. It therefore recommends that VBA gather more detailed data on the determinants of service connection and ratings level for MSA-related PTSD claims, including the gender-specific coding of MSA-related traumas for analysis purposes; and develop and disseminate reference materials for raters that more thoroughly address the management of MSA-related claims. Training and testing on MSA-related claims should be a part of the certification program recommended above for raters who deal with PTSD claims.

Summary Findings and Conclusions

Research reviewed by the committee indicates that PTSD compensation does not, in general, serve as a disincentive to seeking treatment.

It is not appropriate to require across-the-board periodic reexaminations for veterans with PTSD service-connected disability.

Summary Recommendations

VA should consider instituting a fixed long-term minimum level of benefits that would be available to any veteran with service-connected PTSD at or above some specified rating level without regard to that person's state of health at a particular point in time after the C&P examination.

The determination of whether and when reevaluations of PTSD beneficiaries are carried out should be made on a case-by-case basis using information developed in a clinical setting. Specific guidance on the criteria for such decisions should be established so that these can be administered in a fair and consistent manner.

VBA should collect and analyze data on reevaluations so that the system can be improved in the future.

VA should conduct more detailed data gathering on determinants of service connection and rating levels for military sexual assault-related PTSD claims and develop and disseminate reference materials for raters that more thoroughly address the management of such claims. More research is also needed on gender differences in vulnerability to PTSD.

General Observations

In addition to answering the specific questions posed in the charge, the committee made some general observations that flowed from its examination of VA's PTSD disability compensation system. These deal with the overall conduct of the system.

There are three general observations that capture the committee's thinking on the issue of PTSD disability compensation practices.

1. The key to proper administration of VA's PTSD compensation program is a thorough C&P clinical examination conducted by an experienced professional. This echoes the conclusion of an earlier IOM committee that examined issues regarding the diagnosis and assessment of PTSD, which found that:

[A]n optimal assessment of a patient consists of a face-to-face interview in a confidential setting with a health professional experienced in the diagnosis of psychiatric disorders. It is critical that adequate time be allocated for that assessment. Depending on the mental and physical health of the veteran, the veteran's willingness and capacity to work with the health professional, and the presence of comorbid disorders, the process of diagnosis and assessment will likely take at least an hour or could take many hours to complete. (IOM, 2006)

Many of the problems and issues identified in the report can be addressed by consistently allocating and applying the time and resources needed for a thorough PTSD C&P clinical examination. This measure will facilitate:

- more comprehensive and consistent assessment of veteran reports of exposure to trauma;
- more complete assessment of the presence and impact of comorbid conditions;
- the conduct of standardized psychological testing where appropriate;
- more accurate assessment of the social and vocational impacts of identified disabilities;
- evaluation of any suspected malingering or dissembling using multiple strategies including standardized tests, if appropriate, and clinical face-to-face assessment;
- more detailed documentation of the claimant's condition to inform the rater's decision (and thus potentially lead to better and more consistent decisions); and
- an informed, case-specific determination of whether reexamination is appropriate and, if so, when.

VA may well incur increased up-front costs by implementing more consistently detailed examinations for all veterans who present for initial and review C&P evaluations for PTSD. It is not possible, though, to make an informed estimate of what the additional costs may be because the total will depend on many variables whose values are not available or are difficult to derive from public sources—notably, the time currently spent on examinations and the costs associated with those examinations. Further uncertainty is introduced by the fact that a change in policies regarding the exams may lead to changes in the number and characteristics of claimants.

2. An informed evaluation of the PTSD compensation system will not be possible until VA implements a comprehensive data collection, analysis, and publication effort. The report identifies a number of instances where there are gaps in the data and in the research literature regarding PTSD disability compensation issues and offers some specific recommendations to address them. Some data sought by the committee were not available because they were in various cases not collected, not coded, collected but not retained, annotated only in hardcopy files rather than placed in a database, or spread among the VBA and the VHA databases in ways that made retrieval and integration difficult or impossible. The data are handled this way because they are being collected for disparate purposes—the VBA data being primarily associated with the documentation of the delivery of compensation while the VHA data are used to fulfill its mission as a health care delivery network.

The committee believes that an informed evaluation of the PTSD compensation system will not be possible until VA implements a comprehensive and integrated data collection, analysis, and publication effort. This effort should be focused on data useful to research, policy, and planning purposes. It will allow VA to:

- evaluate inter-rater reliability and generate information that can be used to promote the accuracy and validity of ratings;
- more easily determine whether examinations and benefits are being properly and consistently managed throughout the VA system;
- establish whether there are subsections of the population that differ in ways that require the particular attention of the system (such as the elderly, certain racial or ethnic groups, female veterans, those just returning from combat, those with relatively low or with high levels of disability, those with particular comorbidities, and the like); and, most importantly,
- evaluate what is working and what isn't and determine where resources should be focused.

More widely and systematically collecting data for research, policy, and planning purposes and assembling these data in more user-friendly forms will allow VA to better conduct the kinds of analyses needed to make informed decisions about the scope and magnitude of the problems that exist within the PTSD disability compensation system and the best approaches to addressing them, as well as to better project the resources needed to serve future veteran populations.

3. One cannot look at the effect of compensation in isolation. VA offers a range of benefits to veterans with service-related disabilities that is unmatched by civilian benefits systems, including compensation, pension, comprehensive medical care, vocational rehabilitation, employment counseling, education and training, home loans, housing assistance, and other supports to veterans and their families.⁵ It is beyond the scope of this committee to make recommendations regarding the general conduct of the VA benefits and services program. However, the committee notes that a complete evaluation of the strategies for reducing disincentives and maximizing incentives for achieving optimal mental functioning would include the examination of the role of all of these services as well as of the coordination among them. Currently, coordination between VBA- and VHA-administered services is limited, and there is no process in place for individual case planning and management, for integration of services, or

⁵ More severely disabled veterans are eligible for additional and greater benefits, depending on the nature of their disability.

for evaluation of opportunities for providing incentives for improvements in health and function. VA has the opportunity to adopt this broader vision of benefits provision, and the committee believes that PTSD may be a good test case for an integrated benefits approach. As one component of this approach, VA should evaluate the feasibility of decoupling the seeking of PTSD disability through the C&P system from some form of priority access to VHA-provided mental-health services.

The committee is acutely aware that resource constraints—on both funds and staff—limit the ability of VA to deliver services and force difficult decisions on allocations among vital efforts. It believes that increases in the number of veterans seeking and receiving disability benefits for PTSD, the prospect of a large number of veterans of Operation Iraqi Freedom and Operation Enduring Freedom entering the system, and the profound impact of the disorder on the nation's veterans make changes in PTSD C&P policy a priority deserving of special attention and action by VA and the Congress.

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Appendix L

Statement of Separate Views by Commissioner John Holland Grady

In the following four sections, I present several recommendations and positions that differ from those of the Veterans' Disability Benefits Commission. Otherwise, I fully support this report.

1. A New Compensation and Retirement System

The reports by CNA Corporation (CNAC) and the Institute of Medicine (IOM) provide convincing evidence that the current disability benefit system lacks adequate incentives and contains disincentives for disabled veterans to return to work, thus reducing quality of life of some disabled veterans. Consequently, the current system must be changed to encourage and support rehabilitation and return to work.

The President's Commission on Care for America's Returning Wounded Warriors (PCCWW) recommended "A Streamlined DOD/VA Retirement & Compensation System," and I support much of their concept. Transition compensation during the period of rehabilitation should provide a strong incentive to commence and complete a rehabilitation plan. Purposeful participation in the rehabilitation plan should be required for continued eligibility for transition compensation. Performing the rating for earnings loss after the rehabilitation period will more accurately reflect the veteran's ongoing occupational ability. The PCCWW-recommended system requires changes to the Military Retirement System that are consistent with the changes I recommend in Section 3 of this statement. In Section 2 below, I recommend changes to compensation for earnings loss to achieve parity, which are not addressed by the PCCWW; hence, I cannot speak to their views on this aspect. The payment period recommended by the PCCWW for compensation for earnings loss would stop at Social Security retirement age. The compensation payments would be treated as wages for Social Security benefit purposes; therefore, Social Security benefits would be comparable to

those of nondisabled veterans. Conceptually, the combination of veterans' compensation prior to retirement age, with Social Security benefits after retirement age, is an acceptable alternative approach to veterans' benefits compared to the current approach of lifetime compensation payments without Social Security benefits. However, complexities with the approach that includes Social Security benefits are avoided if those benefits are not brought into the design. As one example, compensating veterans who become disabled at older ages for loss of earning capacity is problematic if the compensation ends at age 65 because, according to the CNAC report, significant earnings losses occur after age 65.

I disagree with the PCCWW recommendation that payments for earnings loss should be "recalculated periodically as veterans' conditions or earnings change." This would shift the basis for compensation payments away from loss of average earnings capacity to an individual-based approach. This change would be a step backward because it would be a disincentive to the veteran to attain his or her maximum employment potential. What might be considered overpayments, if these recalculations are not made, will be systematically reduced over time as periodic analyses are made of loss of earnings capacity and adjustments are made to the compensation table.

The new system should modify or eliminate the way occupation is reflected in the rating process, as suggested by IOM, to eliminate or reduce the disincentive to work. Places in the rating schedule where such references currently exist include mental conditions and individual unemployability (IU). For posttraumatic stress disorder (PTSD), with its remitting and recurring pattern, this Commission recommended a "baseline level of benefits to include health care as an incentive for recovery." This approach may be a beneficial change for other conditions as well.

This Commission recommended quality-of-life compensation of up to 25 percent of compensation for earnings loss. Further study will be required to properly design this benefit. Special monthly compensation (SMC), which is provided for a limited number of disabilities, is primarily for the purpose of addressing quality of life. Therefore, the new provision should integrate with and supersede portions of SMC. Also, as discussed in section 2, the current compensation schedule is above parity at the older entry ages. For some older entry ages, the current level of compensation is already far greater than the appropriate level for both loss of earning capacity and quality of life; therefore, any increase for these groups would be inappropriate.

This Commission recommended significant improvements to the effectiveness of the Vocational Rehabilitation & Education program. These improvements are also an essential part of the new system contemplated in this section.

The standard for the appropriate level of income, in my view and, I believe, in the view of the Commission, is *for average income (earnings plus compensation plus retirement benefits) of disabled veterans to be equivalent to average income (earnings plus retirement benefits) of similar nondisabled veterans*. This standard should guide the levels of benefits in the new system.

A new system with the above features would accomplish two very important objectives: (i) align the incentives of the system with the well-being of disabled veterans; and (ii) provide benefit levels that conform to clear standards of appropriateness.

2. Parity in Compensation for Young and Old Entry Ages

Parity means that disability compensation plus earned income of disabled veterans is equivalent to the earned income of similar nondisabled veterans. CNAC measured parity by determining the ratio of earned income plus compensation of disabled veterans to the earned income of nondisabled veterans, using present values at various ages of entry into the compensation system (“entry age”).

Recommendations in this report do not specify whether the compensation table should be revised, upward and downward, to achieve parity by entry age. I believe that the compensation table should be revised to achieve entry age parity by replacing the current single column, which is used for all entry ages, with separate columns for groups of entry ages. The compensation amounts in the new table should be either higher or lower than the current amounts, as necessary, to achieve parity.

The present value of average future earnings subsequent to age 75, for example, is different from the present value of average future earnings subsequent to other ages. For this reason, it is essential for compensation to vary by entry age to provide parity. CNAC’s analysis (Table 17) found that annual compensation amounts of approximately \$40,000; \$30,000; and \$5,000 would provide parity for entry ages of 35, 55, and 75, respectively, for the 100 percent rating. (When considering the parity calculations for the 100 percent rating and the IU rating, it should be remembered that the CNAC analysis does not reflect the Social

Security Disability Insurance (SSDI) benefits that many veterans in these categories receive. As a result, the calculated compensation amounts that provide parity are greater than would be necessary if the government-funded portion of SSDI were included in the analysis.)

As a practical matter, the compensation table could combine entry ages into a few groups, such as (i) fewer than 50 years, (ii) 50–59 years, (iii) 60–69 years, and (iv) 70 years and older. That is, the current one-column schedule would be replaced with a four-column schedule (which should not be difficult to implement). A claimant rated 60% at age 45 would be entitled to the compensation amount for 60% in column (1). If an increase in rating from 60% to 100% is granted at age 65, the claimant would be entitled to an increase in compensation equal to the column (3) 100% amount minus the column (3) 60% amount.

A new compensation table determined in this way will provide parity to disabled veterans relative to the average earnings of nondisabled veterans. Compensation for quality of life is a separate issue, and the Commission recommended that it be addressed with a separate element of compensation.

The natural aversion to implementing benefit decreases can be mitigated in several ways. First, grandfather existing claimants and introduce the new table for future claimants. Second, introduce the new table at the same time as new improvements, such as quality-of-life compensation. Third, introduce the new table at the same time as broader, fundamental changes to the system (see Section 1).

3. Concurrent Receipt

Contrary to the recommendation of the Commission, it is my opinion that it is appropriate for disabled veterans to concurrently receive (with no offset) their military retirement benefit and their disability compensation benefit *only if* the two benefits are each properly designed so that the two benefits together provide the appropriate level of income (see statement at end of Section 1).

Changes in VA compensation and military retirement benefits are required if this condition is to be met; therefore, I do not support concurrent receipt of the two benefits as they now exist. If compensation is changed as discussed in Section 2 above, and if military retirement benefits are changed as discussed below, the two benefits together will achieve the desired objective and concurrent receipt will be appropriate. The Military Retirement System should provide a benefit to

all service members discharged for unfitness based on their years of service and rank (without consideration of their disability rating). There should be no minimum number of years of service required for disability retirement benefits for unfit service members. This benefit would appropriately address the *portion of the service member's career prior to disability*; that is, the disabled veteran would accrue retirement benefit credits for the years prior to disability in the same way as a nondisabled service member who continues on to become eligible for retirement. With the changes described in Section 2, disability compensation for earnings loss would appropriately address the *portion of the career after disability*; that is, the disabled veteran would receive compensation equivalent to the loss in earning capacity from the point of disability forward. The two benefits together would keep the disabled veteran whole relative to the full career of the nondisabled veteran.

This Commission also recommended the elimination of the survivor benefit plan (SBP)/Dependency and Indemnity Compensation offset. I disagree with this recommendation because it would provide greater-than-appropriate benefits for a relative handful of survivors. The CNAC analysis does not support the need for this increase. I believe two different changes are appropriate for survivors. First, the refund of SBP premiums should be changed to include interest, as a matter of equity. Second, Servicemembers' Group Life Insurance (SGLI) should be changed to provide a floor of coverage (such as 10 percent of the maximum coverage) at no cost to the service member. Although, participation in SGLI is high (98 percent), there is likely to be some number of service members who elect little or no coverage, and some of these are likely to be those whose dependants can least afford the loss.

4. Guiding Principle 3:

Benefits should be uniformly based on severity of service-connected disability without regard to the circumstances of the disability (wartime v. peacetime, combat v. training, or geographical location).

Benefit policy has often followed the point of view expressed in the Commission's third guiding principle in the past. However, there have been exceptions, such as the practice of paying lower compensation rates for peacetime service compared to wartime service from 1933 to 1972. Today, Combat Related Special Compensation and some sections of the Wounded Warrior legislation provide special benefits and services to veterans whose disabilities arise under select circumstances. In my opinion, Principle 3 is not appropriate because it regards all circumstances as equally deserving. It leads to benefit policies that are

difficult to reasonably justify, that allocate benefit resources to veterans indiscriminately, and that make it too costly to provide appropriate benefits in the most deserving cases.

The element of sacrifice is a legitimate consideration in determining benefit policy for veterans. Sacrifice, “to permit injury or disadvantage for the sake of something else,” relates to circumstances as well as results. The sacrifice made by a soldier injured in combat is greater than the sacrifice made by a service member injured in an off-duty motorcycle accident or a veteran with type 2 diabetes caused more by obesity than by exposure to Agent Orange. All three examples involve sacrifice for the nation because all three service members volunteered for military service with its inherent obligations and risks. But the three do not involve the same type or degree of sacrifice, even if the severity of disability is the same. In my opinion, it is not appropriate to require, as a matter of principle, that all the benefits and services provided in these three situations be the same. In all cases, the benefits and services should be “above the norm” of civilian benefits; but it is appropriate to allocate the greatest care to the greatest sacrifices.

The lack of discrimination among circumstances results in low respect for the reasonableness of the system. During our site visits, the Commissioners heard VA employees in various roles express dissatisfaction with the current policy in which all circumstances are treated the same. Our survey of raters found that only 28 percent of raters “definitely agree” that the “Disability Rating Process Most Often Arrives at the Right or a Fair Decision.” The reasons for this low response rate are not available from the survey; however, it is consistent with site visit discussions to surmise that the raters’ low opinion of the fairness of the process is, in part, attributable to this issue. Although some disabled veterans support Principle 3, I believe it has a widespread effect of undermining respect for the reasonableness and integrity of veterans’ benefits.

The “Line of Duty” section of the report (Chapter 5), points out that the broad 24x7 definition of line of duty is not found in other countries’ military systems or in American public safety officers’ systems. Nevertheless, the Commission supports this policy and rejects the more typical policy in which off-duty injuries are excluded from benefits. A middle-ground policy, such as one in which a portion of the cost of coverage for off-duty injuries is borne by the service member, should be considered. Such a middle-ground policy would better align the obligation of the nation with the sacrifice of the veteran than does the current 24x7 policy. The “Age as a Factor” policy (Chapter 5) raises the question of

whether disabilities related both to events occurring in military service and to natural aging occurring after military service should entitle individuals to benefits in the same way as disabilities arising directly from military conflict. A policy that considers proportionality of causes, i.e., how much of the responsibility for the disability is related to military service versus natural aging, would be more equitable than policies that assign full responsibility to either military service or natural aging. The compensation amount would be proportionate to the service-related portion of the responsibility. The Commission discussed proportional compensation in the context of presumptive service connection and had concern that this approach would be impractical.

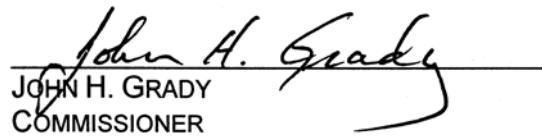
Appropriate differentiations in benefits, based upon guidelines supported by the majority of stakeholders, should be considered. Such guidelines would ensure that (i) proper respect and generosity are shown for all veterans' disabilities; and (ii) greater respect, in the form of greater benefits, is shown for greater sacrifice. Care provided to disabled veterans would be commensurate with the responsibility and gratitude of the nation for the varying degrees of sacrifice made by veterans. Following are examples of differentiations in benefits that might emerge from such consideration:

- a. "On-duty" service connection vs. "Off-duty" service connection: "On-duty" disabilities would be eligible for the normal VA compensation program. "Off duty" disabilities would instead have guaranteed access to a disability income insurance program, with premiums paid by the service member (subsidized by the government as necessary to keep rates at fair market level). Disease-related disabilities would be determined to be either on-duty or off-duty, depending on the circumstances, but would be covered one way or the other. Under this system, an individual entering military service would know that he or she is automatically protected for on-duty disabilities but would need to take advantage of the voluntary insurance program to be protected for off-duty disabilities. Free health care for both on-duty and off-duty disabilities could continue as it is currently.
- b. Proportionality in compensation for disease-related disabilities: For conditions (e.g., type 2 diabetes and prostate cancer) that result from multiple causes, of which the service-related cause may be minor, compensation would be based on the proportion that the service-related cause bears to the total of all causes. Free health care could continue as it is currently.

I am not suggesting that a large number of distinctions be made. Clearly, more distinctions make the system more complex to administer. However, the advantages to be gained by making appropriate distinctions would include (i) greater respect for the reasonableness of veterans' benefits, and (ii) greater fairness in the allocation of benefits to veterans.

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The above four sections summarize the issues that I felt it necessary to address in a separate statement. Notwithstanding these issues, I otherwise support the many important recommendations made by the Veterans' Disability Benefits Commission.



JOHN H. GRADY
COMMISSIONER